(3)

No. 91-1833

In the Supreme Court of the United States

OCTOBER TERM, 1992

EVERETT R. RHOADES, M.D., DIRECTOR OF THE INDIAN HEALTH SERVICE, ET AL., PETITIONERS

v.

GROVER VIGIL, ET AL.

On Writ of Certiorari to the United States Court of Appeals for the Tenth Circuit

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JOINT APPENDIX

KENNETH W. STARR
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Counsel for respondents

PETITION FOR A WRIT OF CERTIORARI FILED: MAY 14, 1992
CERTIORARI GRANTED: OCTOBER 5, 1992

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[1] The opinions of the court of appeals and the opinions of the district court are printed in the appendix to the petition for a writ of certiorari and have not been reproduced here.

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THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF NEW MEXICO

Civil No. 86-1182-JB

GROVER VIGIL, ET AL.

v.

EVERETT R. RHOADES, M.D., ET AL.

RELEVANT DOCKET ENTRIES

DATE	NR	PROCEEDINGS
9/26/86	1	COMPLAINT FOR DECLARATORY AND INJUNCTIVE RELIEF
12/29/86	11	ANSWER by defts., USA
5/22/87	27	ORDER cause be maintained as class action, class consists of all handicapped Indian children who in past received, or who presently are or have been or will be eligible to receive health services from IHS in Albuquerque Area, Navajo Area, Navajo Area and Hopi reservation portion of Phoenix area, including health services formerly available through the Indian Children's program.
12/29/87	67	DEFENDANTS' MOTION TO DISMISS FOR LACK OF JURISDICTION OR IN THE ALTERNATIVE FOR SUMMARY JUDGMENT
12/30/87	68	PLAINTIFFS' MOTION FOR PARTIAL SUMMARY JUDGMENT

DATE	NR	PROCEEDINGS
7/6/90	104	MEMORANDUM OPINION AND ORDER that defts' M/to Dismiss for Lack of Jurisdiction and in the Alternative for Sum Judg is denied; pltfs' M/for Partial Summary Judgment is granted in part; parties w/in 15 days of this Memorandum shall submit supplemental briefs addressed solely to the question whether an injunction should issue compelling reinstatement of the Indian Children's Program as it existed and functioned immediately prior to its termination in 1985.
8/28/90	113	MEMO OPINION AND ORDER re: Supplemental Memoranda filed by parties pursuant to Court's 7-6-90 Memo and Opinion
10/26/90	114	NOTICE OF APPEAL by defts., from the Court's Memorandum opinions & Orders entered on 8/28/90 & 7/6/90.

UNITED STATES COURT OF APPEALS
FOR THE TENTH CIRCUIT

No. 90-2235

GROVER VIGIL, ET AL.

v.

EVERETT R. RHOADES, M.D., ET AL.

RELEVANT DOCKET ENTRIES

DATE	NR	PROCEEDINGS
11/6/90	1	Civil Case Docketed.
1/15/92	31	Terminated on the Merits after Oral Hearing; Judgment is Affirmed; Written, Signed, Published. Seymour, panel member; Barrett, panel member; Baldock, authoring judge.

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF NEW MEXICO

CIV 86-1182 JB

GROVER VIGIL and CHARLENE VIGIL as General Guardians and Next Friends for ASHLEY VIGIL, a minor person,

—and—

KEE SANDOVAL and JUDY SANDOVAL as General Guardians and Next Friends for KRISTOFFERSON SANDOVAL, a minor person,

—and—

ANGELA C. ALLEN, as General Guardian and Next Friend for ANGELO ALLEN, a minor person, individually and on behalf of all other persons similarly situated, PLAINTIFFS

vs.

EVERETT R. RHOADES, M.D., Director of the Indian Health Service, his agents, employees, and successors; OTIS R. BOWEN, Secretary of the Department of Health and Human Services, his agents, employees, and successors; THE DEPARTMENT OF HEALTH AND HUMAN SERVICES; DONALD O. HODEL, Secretary of the Department of the Interior, his agents, employees, and successors; ROSS SWIMMER, Assistant Secretary of the Interior-Indian Affairs, Bureau of Indian Affairs United States Department of the Interior, his agents, employees, and successors; THE DEPARTMENT OF THE INTERIOR; and the UNITED STATES OF AMERICA, DEFENDANTS

COMPLAINT FOR DECLARATORY AND INJUNCTIVE RELIEF

[Filed Sep. 26, 1986]

1. This is a class action for declaratory and injunctive relief designed to ensure access to and provision of health and medical services for which plaintiffs are eligible and which defendants are obligated to provide. Plaintiffs seek to have this court declare unlawful and enjoin certain policies and practices, and actions and inactions of defendants, in regard to their provision of health and medical services to handicapped Indian children in the Southwest. Plaintiffs challenge the termination of health and medical services through the Indian Children's Program and defendants' resulting failure to ensure provision of these services to these children.

Plaintiffs seek a declaratory judgment that defendants' actions in terminating health and medical services through the Indian Children's Program and its policies and practices, and actions and inactions in regard to provision of these services to these children are variously in violation of defendants' federal trust responsibility to plaintiffs, the Administrative Procedure Act, plaintiffs' due process rights under the Fifth Amendment to the United States Constitution, the Indian Health Care Improvement Act, the Snyder Act, various rules and regulations promulgated by defendants which govern Indian health care, and are arbitrary and capricious, an abuse of discretion, and contrary to law.

In addition and in the alternative, plaintiffs seek a mandatory or injunctive decree compelling defendants to: (1) provide access to essential diagnostic, evaluation, treatment planning, and therapy services to plaintiffs; (2) develope, implement, and maintain a system at each service unit in the Albuquerque Area, Navajo Area, and Phoenix Area of the Indian Health Service to identify handicapped Indian children and to ensure that they receive such ongoing health and medical care which will

enable them to attain and maintain optimal physical, mental, and emotional health; (3) develop and implement a national level policy with respect to their obligation to provide health and medical services to handicapped Indian children; (4) withdraw their decision to terminate direct clinical care health and medical services through the Indian Children's Program to plaintiffs and to restore the Program's services to them; (5) notify the children receiving Indian Children's Program Services at the time of its termination of health and medical services available to them as handicapped individuals through the Indian Health Service, and of administrative grievance procedures available to them if such services are denied; and (6) promulgate, publish, and obtain public comments on any rule or decision-making which reduces or eliminates direct clinical care health and medical services through the Indian Children's Program to handicapped Indian children.

II. JURISDICTION

2. Jurisdiction is conferred upon this court by 28 U.S.C. § 1331 and 28 U.S.C. § 1337 in that plaintiffs' claims arise under the Constitution and laws of the United States; and by 28 U.S.C. § 1361 in that this is an action to compel an officer or agency of the federal government to perform duties owed to plaintiffs.

3. Judicial review of agency action is authorized by 5 U.S.C. § 702.

4. Declaratory relief sought by plaintiffs is authorized by 28 U.S.C. §§ 2201 and 2202.

5. Venue is proper in the District of New Mexico under 28 U.S.C. § 1391.

III. PLAINTIFFS

6. Plaintiffs' Grover Vigil and Charlene Vigil are a married couple residing in the County of Sandoval, State of New Mexico. They are parents of Ashley A. Vigil, a

minor child who resides with them. Grover Vigil is a member of the Jicarilla Tribe.

7. Plaintiff Angela C. Allen is a resident of the County of San Juan, State of New Mexico. She is the mother of Angelo Allen, a minor child who resides with her. Angela Allen and Angelo Allen are members of the Navajo Tribe.

8. Plaintiffs' Kee Sandoval and Judy Sandoval are a married couple residing in the County of San Juan, State of New Mexico. They are parents of Kristofferson Sandoval, a minor child who resides with them. Kee Sandoval, Judy Sandoval, and Kristofferson Sandoval are members of the Navajo Tribe.

IV. CLASS ACTION

9. Plaintiffs bring this action individually and as class representatives on behalf of all other persons similarly situated pursuant to Rule 23 of the Federal Rules of Civil Procedure. Plaintiffs represent a class of all handicapped Indian children who in the past received, or who presently are, have been, or will be eligible to receive health services from Indian Health Service in the Albuquerque Area, and Phoenix Area, including health services formerly available through the Indian Children's Program.

10. The class is so numerous that joinder af all members is impracticable. Although the exact number is unknown, based on information and belief, there are over 2000 handicapped Indian children who have been served by the Indian Children's Program. The exact number of such children should be known by defendants and should be able to be readily obtained from them through discovery. The total number of children eligible for Program services is unknown but is believed to be substantially larger number than those actually served by the Program. On or about October 1, 1985, the Program terminated services to approximately 216 handicapped Indian children alone.

11. There are questions of law or facts common to the class. Defendants have terminated direct clinical care

services through the Indian Children's Program to all members of the class, have failed to notify them of this termination or afford them any due process in connection with their termination of services, and have generally failed to ensure that they are provided with the necessary health and medical services to which they are entitled.

12. Plaintiffs' claims are typical of the class in seeking declaratory and injunctive relief for violations of defendants' federal trust responsibility to provide adequate health care, the Administrative Procedure Act, plaintiffs' due process rights under the Fifth Amendment to the U.S. Constitution, the Indian Health Care Improvement Act, the Snyder Act, various rules and regulations promulgated by defendants which govern Indian health care, and on the basis that defendants' acted arbitrarily and capriciously, abused their discretion, and acted contrary to law.

13. Plaintiffs will fairly and adequately represent and protect the interests of the class.

14. Defendants have acted and failed or refused to act on grounds generally applicable to the class, thereby making appropriate preliminary and final injunctive relief and declaratory relief with respect to the class as a whole.

V. DEFENDANTS

15. Defendant Everett R. Rhodes, M.D., is the Director of the Indian Health Service, a special branch of the Public Health Service, in the Department of Health and Human Services, and has overall responsibility for management and supervision of the Indian Health Service.

16. Defendant Otis R. Bowen is the Secretary of the Department of Health and Human Services and has overall responsibility for management and supervision of Department, including the Indian Health Service.

17. Defendant United States Department of Health and Human Services is an agency of the federal government of the United States of America which administers programs and supervises matters relating to health in the United States, including the Indian Health Service and Indian health.

18. Defendant Donald O. Hodel is Secretary of the Department of the Interior and has overall management and supervision of the Department, including the Bureau of Indian Affairs.

19. Defendant Ross Swimmer is the Assistant Secretary of the Interior Department-Indian Affairs, Bureau of Indian Affairs and has overall management and supervision of the Bureau of Indian Affairs, including the Office of Indian Educational Programs.

20. Defendant United States Department of the Interior is an agency of the federal government of the United States of America which includes the Bureau of Indian Affairs and which administers programs and supervises matters relating to Indians in the United States, including the Office of Indian Educational Programs of the Bureau of Indian Affairs.

VI. STATEMENT OF FACTS

21. Ashley Vigil is a three year old child born on January 28, 1983. She has been diagnosed as having cerebral palsy and was born with congenital heart disease. At six months she began receiving health and medical services through the Indian Children's Program. She was evaluated by a team of specialists and received physical therapy on a monthly basis until June, 1985. After that time, no one from the Indian Children's Program saw her and she received no further services through the Program. She was not notified of termination of the Program or of its services to her. She was not referred elsewhere for treatment, nor informed by the Indian Health Service or Indian Children's Program as to what medical or health services she would continue to need or where she might obtain them.

22. Kristofferson Sandoval is a five year old child born on June 16, 1981, at the Gallup Indian Medical Center in Gallup, New Mexico. Following his birth, he was regularly taken to his well baby clinics. However, by the time he was two and a half years old, his mother felt he was not developing normally and reported her feelings to Indian Health Service personnel at three or four well baby clinics. However, no suggestions were made as to how she might verify if he had any special problems; no referrals were made, and no action was taken by the Indian Health Service to evaluate for any developmental disability.

In 1984, during a hospitalization, Kris was noted by hospital personnel to be very different from other children his age and difficult to handle. Again, however, the Indian Health Service failed to refer him for any evaluation or treatment or take any action itself to determine any disability.

After herself learning about the Indian Children's Program, Judy Sandoval was able to obtain services from the Indian Children's Program. ICP clinicans saw Kristofferson on an almost monthly basis until approximately April, 1985. After that time he received no further services through the Program. He was not notified of the termination of the Program or of its services to him.

Since termination of the Indian Children's Program services, Kristofferson has not received any direct care treatment from the Indian Health Service on an on-going basis. Despite specific referrals to the Indian Health-Service, Kristofferson has received only a fifteen minute examination by a psychiatrist at the Gallup Indian Medical Center in Gallup and a drug prescription.

23. Angelo Allen is a five year old child born on April 8, 1981. Six months after his birth during his six months check up at the Indian Health Services hospital in Shiprock, New Mexico, it was determined that Angelo was mentally retarded. He subsequently at age three began receiving Indian Children's Program services which continued until the summer of 1985. Prior to cessation of ICP services, his clinician verbally informed Angela that ICP might be discontinued. However, she never received any formal or written notification of termination of services nor was she informed where she might obtain substitute and alternative services or referred to them. Since termination of ICP services, Angelo has not received any direct care treatment or monitoring. One referral was made by Indian Health Services to a private hospital in Farmington for an E.K.G.

24. The Indian Children's Program was an activity of the Office of Mental Health Programs of the Indian Health Service which was co-sponsored by the Office of Indian Educational Programs of the Bureau of Indian Affairs.

25. The Indian Children's Program was a predominantly regional program which provided evaluation, diagnostic, treatment planning, therapy, and consultation services to Indian children in the Albuquerque Area, Navajo Area, and portions of the Phoenix Area (primarily the Hopi Reservation) of the Indian Health Service.

26. Children from birth through twenty one years of age who had, were suspected of having, or were at risk of having a physical, mental, emotional handicap or combination of handicaps who were eligible for services from the Indian Health Service or Office of Educational Programs of the Bureau of Indian Affairs were eligible for Indian Children's Program services. Severity of handicap was not a consideration for eligibility.

27. The majority of diagnostic categories seen by the Indian Children's Program were learning disabled, emotionally disturbed, mentally retarded, cerebral palsied, communication disordered, and the multiply handicapped.

28. Direct clinical care services were often provided to children in their homes in remote areas without ready access to any medical facilities.

29. The Indian Children's Program was a successful demonstration of highly skilled clinical teams delivery of essential diagnostic, evaluation, treatment planning, therapy, and consultation services to handicapped Indian children in remote Indian communities.

30. Sometime during the summer of 1985, an Indian Health Service decision was made at the national level to eliminate the Indian Health Service clinical component of the Indian Children's Program.

31. As of October 1, 1985, provision of direct Indian Children's Program health and medical services to handicapped Indian children was discontinued.

32. Approximately 216 cases were closed out beginning October 1, 1985.

33. During the fall of 1985, the Indian Children's Program held a series of community meetings to present closing patient information on cases of children in the Shiprock, Crownpoint, Zuni, and Gallup areas of New Mexico who had undergone treatment by the Indian Children's Program staff.

34. The Shiprock meeting on November 13, 1985, determined that there was a lack of sufficient resources to meet the needs of Indian children in the areas of motor evaluation/therapy and psychological evaluation/treatment from all available sources, including the Indian Health Service.

35. The Shiprock meeting determined that there was a lack of full evaluation and ongoing treatment services to Indian children ages birth to five.

36. The Crownpoint meeting on November 20, 1985, determined that there was a lack of sufficient resources to meet the needs of Indian children in the area of motor evaluation/therapy, speech/language evaluation/therapy, cognitive/developmental evaluation, and preschool placement, from all available sources, including the Indian Health Services.

37. The Crownpoint meeting determined that there was a lack of evaluation and ongoing treatment services to Indian children ages birth to five.

38. The Zuni meeting on November 21, 1985, determined that there was a lack of psychological services, particularly in the identification and/or treatment/educational planning for behavior disordered children, occupational therapy, and physical therapy.

39. The Zuni meeting determined that the needs, services, and treatment plans for handicapped Zuni children needed to be monitored and coordinated on an on-going basis.

40. The Gallup meeting on January 14, 1986, determined that there was a lack of sufficient resources to meet the needs of Indian children in the areas of motor evaluation/therapy, cognitive/development evaluation, preschool placement, and psychological evaluation/therapy from all available sources, including the Indian Health Service.

41. The children who had been receiving Indian Children's Program services were not themselves notified of the decision to terminate direct services to them nor were they notified of or provided with any administrative or other grievance procedures.

42. The children who had been receiving Indian Children's Program services were not referred to other service providers for necessary services.

43. Subsequent to the termination of Indian Children's Program services, the Indian Health Service failed to provide necessary services to children who had been receiving them or to children who were eligible for them to fill the gap left by termination of Indian Children's Program services.

44. Most of the children served by the Indian Children's Program are not aware of any alternative health services which might have been available to them or how to go about obtaining such services, but are dependent

upon the Indian Health Service for provision of their health and medical care.

45. Early detection and intervention services for handicapped Indian children are crucial; without early detection and intervention, many pre-school age children will be further handicapped by the time they reach mandated school programs for the handicapped.

46. As a result of the termination of Indian Children's Program services, handicapped Indian children who were served by the Program and who would have been eligible to receive its services have been irreparably harmed and will continue to be irreparably harmed until the Indian Health Service again makes these services available.

47. At no time have defendants promulgated, published, or obtained comment on any rule implementing their decision to terminate Indian Children's Program direct clinical services as required by the Administrative Procedure Act, 5 U.S.C. §§ 552 and 553 and *Morton v. Ruiz*, 415 U.S. 199 (1974).

48. At no time have defendants provided children served by the Indian Children's Program with any due process connected with their termination of their services as required by the Fifth Amendment to the U.S. Constitution.

49. Plaintiffs have a legitimate claim of entitlement to continued Indian Children's Program direct clinical services sufficient to constitute a protected property interest under the Fifth Amendment to the U.S. Constitution absent notice and opportunity to be heard prior to termination of these services.

VII. FIRST CLAIM FOR RELIEF

50. Plaintiffs restate and incorporate by this reference the fore-going paragraphs herein.

51. Insofar as defendants' have failed to promulgate, publish, or obtain public comment on any rule implementing their decision to terminate Indian Children's Program

services to handicapped Indian children, they have violated the requirements of the Administrative Procedure Act, 5 U.S.C. §§ 552 and 553 and *Morton v. Ruiz*, 415 U.S. 199 (1974).

VIII. SECOND CLAIM FOR RELIEF

52. Plaintiffs restate and incorporate by this reference the fore-going paragraphs herein.

53. Insofar as plaintiffs participated in essential Indian Children's Program services which defendants provided and for which they were eligible, insofar as defendants have failed or refused to notify plaintiffs of their decision to terminate their services, and insofar as defendants have failed or refused to provide plaintiffs with administrative grievance procedures, they have, by their summary termination of the Program, violated plaintiffs right to procedural due process under the Fifth Amendment to the U.S. Constitution.

54. Plaintiffs have a legitimate claim of entitlement to continued Indian Children's Program direct clinical services sufficient to constitute a protected property interest under the Fifth Amendment to the U.S. Constitution absent notice and opportunity to be heard prior to termination of these services.

IX. THIRD CLAIM FOR RELIEF

55. Plaintiffs restate and incorporate by this reference the foregoing paragraphs herein.

56. By terminating services it had been providing to handicapped Indian children through the Indian Children's Program and by its actions and inactions in failing to ensure access to and provision of essential diagnostic, evaluation, treatment planning, and therapy services to plaintiffs, defendants have violated the provisions of the Snyder Act, 25 U.S.C. § 13, requiring them to direct, supervise, and expend such monies as Congress may appropriate for

the relief of distress and conservation of health of Indians in the United States.

X. FOURTH CLAIM FOR RELIEF

57. Plaintiffs restate and incorporate by this reference the foregoing paragraphs herein.

58. By terminating services it had been providing to handicapped Indian children through the Indian Children's Program and by its actions and inactions in failing to ensure access to and provision of essential diagnostic, evaluation, treatment planning, and therapy services to plaintiffs, defendants have violated the policy set out in the Indian Health Care Improvement Act, 25 U.S.C. § 1601 et seq. requiring federal health services to maintain and improve the health of Indians.

XI. FIFTH CLAIM FOR RELIEF

59. Plaintiffs restate and incorporate by this reference the foregoing paragraphs herein.

60. By terminating services it had been providing to handicapped Indian children through the Indian Children's Program, defendants:

(a) failed to follow their own rules and regulations as set out in the Indian Health Services Manual Part 3, Chapter 3; and

(b) failed to follow their own regulations set out at 12 C.F.R. § 36.1 et seq. regarding services available and persons to whom services will be provided.

61. By their actions, defendants have acted arbitrarily and capriciously, have abused their discretion, and have acted contrary to law, whereby plaintiffs have suffered injury. Plaintiffs therefore have a claim for relief under the Administrative Procedure Act, 5 U.S.C. §§ 702, 706.

XII. SIXTH CLAIM FOR RELIEF

62. Plaintiffs restate and incorporate by this reference the foregoing paragraphs herein.

63. By their actions and inactions as set out above herein defendants have violated their federal trust responsibility to provide essential diagnostic, evaluation, treatment planning, and therapy services to plaintiffs.

XIII. EQUITY

64. Plaintiffs are clearly entitled to relief on the merits of this case and are threatened with severe, irreparable injury unless mandatory preliminary injunctive relief is granted. Defendants will suffer no injury if such relief is granted because it is little more than their duty under law and any burden placed on defendants is outweighed by the injury to plaintiffs. Such relief would not be adverse to but in the public interest.

XIV. PRAYER FOR RELIEF

65. Plaintiffs pray that this court certify this action as a class action pursuant to Rule 23 of the Federal Rules of Civil Procedure at its earliest opportunity.

66. Plaintiffs pray that this court issue a declaratory judgment pursuant to 28 U.S.C. §§ 2201 and 2202 that defendants' actions in terminating direct clinical care health and medical services to handicapped Indian children through the Indian Children's Program are in violation of defendants's federal trust responsibility to plaintiffs, the Administrative Procedure Act, plaintiffs' due process rights under the Fifth Amendment to the United States Constitution, the Snyder Act, the Indian Health Care Improvement Act, various rules and regulations promulgated by defendants which govern Indian health care and are arbitrary and capricious, an abuse of discretion, and contrary to law.

67. Plaintiffs pray that this Court grant preliminary and permanent injunctive relief ordering defendants to: (1) provide access to essential diagnostic, evaluation, treatment planning, and therapy services to plaintiffs, and (2) withdraw their decision to terminate direct clinical care health and medical services through the Indian Children's Program to plaintiffs and restore the Program's services to them.

68. Plaintiffs pray that this Court grant mandamus relief pursuant to 28 U.S.C. § 1361 compelling defendants to: (1) develop, implement, and maintain a system at each service unit in the Albuquerque Area, Navajo Area, and Phoenix Area of the Indian Health Service to identify handicapped Indian children and to ensure that they receive such ongoing health and medical care which will enable them to attain and maintain optimal physical, mental, and emotional health; (2) develop and implement a national level policy with respect to their obligation to provide health and medical services to handicapped Indian children; (3) notify the children receiving Indian Children's Program services at the time of its termination of health and medical services available to them as handicapped individuals through the Indian Health Service, and of administrative grievance procedures available to them if such services are denied; and (4) promulgate, publish, and obtain public comments on any rule or decision-making which reduces or eliminates direct clinical care health and medical services through the Indian Children's Program to handicapped Indian children.

69. Pray that this court award them their reasonable costs and attorney's fees.

70. Pray that this court grant them such further and additional relief as may be just and proper.

Respectfully submitted,

By /s/ Joel Jasperse
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(Verification Omitted in Printing)

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF NEW MEXICO

(Caption Omitted in Printing)

ANSWER

[Filed Dec. 29, 1986]

Comes now the United States of America, by and through its attorneys, William L. Lutz, United States Attorney for the District of New Mexico, and Raymond Hamilton and Ronald F. Ross, Assistant United States Attorneys for said District, and states as follows:

1. Plaintiffs' allegations in paragraph 1 of the complaint are characterizations of plaintiffs' suit and therefore do not need a response, but to the degree that a response is deemed necessary, those allegations are denied.

2. Defendant denies the allegations contained in paragraphs 2, 3, 4, 5, 9, 10, 11, 12, 13, 14 and 44 of plaintiffs' complaint.

3. Defendant admits the allegations contained in paragraphs 6, 7, 8. 16, 17, 18, 19, 20, 24, 26, 27 and 45 of plaintiff's complaint.

4. Defendant admits the allegations contained in paragraph 15 except that defendant's surname is spelled Rhoades.

5. Defendant is without sufficient information to form a belief as to the allegations in paragraphs 21, 22 and 23 of plaintiffs' complaint and therefore denies same.

6. Defendant denies the allegations contained in paragraph 25 of plaintiff's complaint except to admit that the Indian Children's Program (ICP), on a referral basis,

performed diagnostic examinations, developed long term treatment plans, and monitored treatment programs, as consultants to local IHS Service Unit personnel who had the responsibility to provide or arrange for ongoing treatment within the constraints of IHS and other available resources. In some cases, ICP staff and contractors did provide limited direct clinical services, such as physical therapy, during diagnostic examinations and periodic visits to monitor long term treatment programs carried out by local practitioners. The ICP provided these services to Indian children in the IHS Albuquerque and Navajo Areas, and in portions of the IHS Phoenix Area (primarily the Hopi reservation).

7. Defendant denies the allegations contained in paragraph 28 of plaintiffs' complaint except to admit that while the services described in answer to No. 25 above were occasionally provided to children in their homes, the services were usually provided in a clinic environment.

8. Defendant denies the allegations contained in paragraph 29 of plaintiffs' complaint except to admit that the ICP provided the services described in answer No. 25 above to handicapped Indian children in remote Indian communities with limited success.

9. Defendant denies the allegations contained in paragraph 30 of plaintiffs' complaint except to admit that the IHS decided at the national level in October, 1984 to phase out services from ICP described in answer to No. 25 above. Defendants aver that program management technical assistance (technical assistance and training to help IHS staff and others in local communities work as a team to establish their own programs to care for ~~han~~dicapped Indian children, accessing both IHS and non-IHS resources) is a continuing responsibility of the ICP.

10. Defendant denies the allegations contained in paragraph 31 of plaintiffs' complaint except to admit that the services from ICP described in answer to No. 25 above ceased as of October 1, 1985.

11. Defendant denies the allegations contained in paragraph 32 of plaintiffs' complaint except to admit that the services from ICP described in answer to No. 25 above ceased in approximately 426 cases.

12. Defendant denies the allegations contained in paragraph 33 of plaintiffs' complaint except to admit that the ICP held a series of community meetings in the Shiprock, Crownpoint, Zuni and Gallup areas in the last quarter of fiscal year 1985 to discuss continuing case management for the approximately 426 children referred to in answer to No. 32 above.

13. Defendant denies the allegations contained in paragraphs 34, 35, 36, 37, 38, 39, and 40 of plaintiffs' complaint except to admit that the community meetings discussed ongoing case management and availability of IHS and non-IHS resources.

14. Defendant is without sufficient information to form a belief as to the allegations in paragraph 41 of plaintiffs' complaint and therefore denies same. Defendants aver that the ICP did not have primary responsibility within the IHS for providing "direct services" to handicapped Indian children, nor did the IHS "terminate direct services" to handicapped Indian children when ICP services described in answer to No. 25 above ceased. There is no obligation to provide administrative grievance procedures.

15. Defendant denies the allegations contained in paragraph 42 of plaintiffs' complaint. Defendants aver that local practitioners were provided with information on alternative resources.

16. Defendant denies the allegations contained in paragraph 43 of plaintiffs' complaint. Defendants aver that to the extent resources permit, services for children with handicapping and chronic conditions have and continue to be provided by each IHS service unit and by available resources such as other Federal programs, and State and local programs.

17. Plaintiffs' allegations in paragraphs 46 through 64 of the complaint are conclusions of law and therefore do not need a response, but to the degree that a response is deemed necessary, those allegations are denied.

18. Plaintiffs' allegations in paragraphs 64 through 70 constitute plaintiffs' prayer for relief which requires no response, but to the degree that a response is deemed necessary, defendant requests that plaintiffs' prayer be denied.

All allegations of the complaint not specifically admitted herein are denied.

First Defense

The court lacks subject matter jurisdiction over the instant suit.

Second Defense

The complaint fails to state a claim upon which relief can be granted.

Third Defense

The Court lacks jurisdiction over the instant suit in that any and all actions by Federal defendants, of which plaintiffs complain, are committed to agency discretion by law and, therefore, are not reviewable under the Administrative Procedure Act, 5 U.S.C. § 701(a)(2).

All 12(b) defenses raised herein shall be supplemented by motions and briefs pursuant to Rule 9(d) *United States District Court Rule.*

Respectfully submitted,

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United States Attorney

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(Certificate Omitted in Printing)

HEALTH SERVICES ADMINISTRATION
INDIAN HEALTH SERVICE

DATE: January 31, 1978

TO: All Area Directors
Indian Health Service
Attn: P.L. 94-437 Coordinator

FROM: Director,
Indian Health Service

SUBJECT: Mental Health Diagnostic and Treatment Center—The Indian Childrens' Center

Congressional authorization and appropriations, under PL 94-437 (Title II), have mandated that a childrens' residential diagnostic and treatment center be established within the Mental Health Programs of I.H.S. This action came directly from many expressions of a strong traditional Native American and Alaska Native interest in caring for unfortunate children. The National Indian Health Board recently reaffirmed this concern with a forceful resolution supporting "The Indian Childrens' Village" as an IHS wide service facility.

Preliminary progress in developing this project has moved rapidly under the immediate direction of Dr. Theodore C. Marrs, Albuquerque Chief, Maternal and Child Health, and a developmental team in the Albuquerque Area Office. This group has worked closely with the Headquarters Mental Health Programs, Dr. H. C. Townsley, Chief. A few highlights of this process include unanimous Laguna Pueblo Governor and Council endorsement for construction of facilities on Tribal land, support from the Albuquerque City Council and Chamber of Commerce, major interest by the University of New Mexico School of Medi-

cine Departments of Psychiatry and Pediatrics, etc. Funding for FY 78 activities and authorization for eleven positions have been provided to Mental Health Programs, headquarters office. The program of requirements (P.O.R.), staffing and budget breakouts, and initial engineering and architectural plans are underway. A preliminary progress report, containing additional details, is being sent to all of you through Dr. Townsley's office. I suggest you duplicate my memorandum and this preliminary report and send it to all service unit directors, appropriate branch chiefs, and Tribal health boards since this project is of such imminent and wide interest.

The Indian Childrens' Village is of special timeliness since PL 94-142 has ordered free educational opportunities for handicapped children and a multidisciplinary diagnostic and therapeutic model is essential to carrying out this mandate. It is also a unique opportunity for BIA and IHS cooperation, a role which has already been started by provision of IHS data in support of BIA needs under PL 94-142 and their oral commitment to us of their intent to fund essential educationally related and other support positions with the Village.

In addition to the foregoing, this project provides a model, in the best sense of Indian Self Determination, through its use of a twenty year lease with private sector construction funding. The potential significance of this administrative point is clear to each of you.

The decision has been made that the first executive director of this program should be a board certified pediatrician with broad background in Mental Health and Administrative matters. We hope this decision will help in building an image for the Village of the concern for the *total* child.

Dr. Ted Marrs, on a part time basis, has been and will continue to serve as acting Executive Director until formal

advertising and selection has been made. He has an extensive professional and administrative background and is well prepared to continue in this Acting capacity.

Finally, it is with special pleasure that I recognize and thank Acting Director, Dr. Jack Ellis, and Area Director Mr. Jay Harwood of the Albuquerque Area for their sustained interest and devotion to this project. They have been personally cooperative and have allowed Area staff to spend considerable time in developing this program to date. We will continue to be appreciative of their help.

I call upon each Area Directors to strongly support this project as a much needed and requested national resource. Your continued support and the success of this first project may well open doors to the establishment of other such facilities at various locations.

/s/ Emery A. Johnson, M.D.
EMERY A. JOHNSON, M.D.
Assistant Surgeon General

[SEAL]

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
PUBLIC HEALTH SERVICE
HEALTH SERVICES ADMINISTRATION

Indian Children's Program
Indian Health Service
2401 12th Street, N.W.
Albuquerque, New Mexico 87102

February 8, 1980

MEMORANDUM

TO: Assistant Secretary for Indian Affairs
Dept. of the Interior

FROM: Acting Director, Indian Children's Program
Co-Director, Indian Child Study Project
(Bureau of Indian Affairs)

SUBJECT: Indian Child Study Project—Bureau of Indian Affairs/Indian Health Service

In 1978 action was initiated by the Indian Health Service, with the support of several Indian tribes, to obtain an appropriation of funds from the U.S. Congress to construct a diagnostic and treatment planning facility for Indian children near Albuquerque, New Mexico. Because of an unsupportive position taken by the Bureau of Indian Affairs before the House Appropriations Committee, the project was not funded. Subsequent to the House Appropriations Committee hearings, representatives of the Bureau of Indian Affairs and the Indian Health Service met with Congressman Sidney Yates, at which time the representatives were instructed to devlop a cooperative effort to determine whether or not the Bureau of Indian Affairs and the Indian Health Service could operate a joint program designed to provide diagnostic, treatment planning, and treatment services for handicapped chil-

dren. Further, to develop a position on the need of a multidisciplinary medical/education complex to provide these services.

Following several meetings between representatives of the Indian Health Service and the Bureau of Indian Affairs, the joint Bureau of Indian Affairs/Indian Health Service cooperative project, now known as the Indian Child Study Project, was developed and was commenced in June 1979 with a letter of commitment to Congressman Yates from Deputy Assistant Secretary for Indian Affairs, Mr. Rick Lavis, a copy of which is attached. In August 1979, Ms. Ann Crawley was officially appointed as Co-Director of the Child Study Project for the Bureau of Indian Affairs (see attachment) and has been serving in such capacity on a part-time basis. The following constitutes a report of the first 90 days operation of the Project as committed in the letter of June 28, 1979, to Congressman Yates.

The Bureau of Indian Affairs on September 13, 1979, allocated $350,000 of year-end money, which was transferred to the Albuquerque Area Office of the Bureau of Indian Affairs. Considering the nature of funds and the time constraints for actual obligation of the funds, it was determined through mutual agreement of the Project Director and Co-Director that the funds could be best utilized to the greatest benefit as follows:

1. The Bureau of Indian Affairs would, through the means of contracts, support and supplement the existing Indian Health Service—Indian Children's Program with:

   a. Additional staff to supplement and complement the Indian Children's Program multidisciplinary outreach team with the following positions:

      Educational Diagnosticians
      Speech Therapist

Vocational Rehabilitation Specialist
Social Worker
Child Psychologist
Expressive Arts Therapist
Administrative and Clerical Personnel.

b. Funds for administrative support services.

c. Funds for defraying costs related to transportation and lodging of patient children, and their parents or escorts, brought to Albuquerque, New Mexico, for diagnosis and evaluation through the University of New Mexico School of Medicine.

d. Funds for initiation of the SOMPA Project, a project designed to determine the possibility and practicability of establishing culturally oriented testing norms.

e. Funds for the determination of available resources or lack thereof and the development of a resources handbook.

The Indian Health Service—Indian Children's Program, likewise, received an allotment of year-end funds which were obligated via contracts, as follows:

1. A contract was entered into with the University of New Mexico School of Medicine to provide diagnostic, evaluative, treatment planning, and limited treatment services for handicapped children referred by the Indian Children's Program on either an inpatient or outpatient basis. These services are intended to be utilized where such servives are not available locally or cannot be provided by the staff of the Indian Children's Program or other local resources.

2. In addition, the Indian Children's Program would make available to the Study Project its regular program staff consisting of the following disciplines:

   Clinical Psychologist
   Social Worker

Occupational Therapist
Physical Therapist
Speech Therapist
Child Psychiatrist

During the initial phase of this project, both agencies, the Indian Health Service and the Bureau of Indian Affairs, at the local level, worked on specifics for the program and developed plans for subsequent fiscal years. The Project directorship is presently analyzing the current activities; identifying problems, solutions or alternatives; identifying the types of services needed or being requested and developing ways to meet them; developing policies and procedures; and determining future program direction. As opportunities occur, changes and modifications are being implemented. The Project directorship is also involved in the following specific actions:

1. Reviewing and redesigning the organizational structure of the Indian Children's Program to reflect a joint Indian Health Service-Bureau of Indian Affairs activity (a copy of the proposed organizational chart and functional statements is attached.).

2. Developing and implementing necessary administrative and clinical processes and procedures governing the operations of the outreach team and staff (see attachment).

3. Delineating specific agency responsibilities.

The increase in staff has resulted in a porportionate increase in the Indian Children's Program's capability to provide services. Attached is a detailed report of the specific services rendered during the reporting period and a cumulative report of services provided during the Fiscal Year 1979. The report provides information as to the number and types of services provided, the findings and the recommendations for follow-up care.

Conclusions which can be drawn from report are as follows:

1. There exists a tremendous unmet need for diagnostic, evaluative, treatment planning and treatment services for handicapped Indian children.
2. There exists serious shortage or lack of available local resources to meet such needs.
3. The multidisciplinary team approach is a viable means of partially meeting such needs.
4. Methods and means of providing services where local resources are totally non-existent or severly limited, and where the handicapping conditions of children are so severe or that the services of the outreach team would be inadequate, must be developed and implemented.
5. The multidisciplinary outreach team approach can be a workable and practical approach to a cooperative effort of providing such services to handicapped Indian children, thus permitting both agencies of a means of partially meeting the legal mandates of P.L. 94-142 and P.L. 94-437.
6. The current level of permanent funding and program staffing is grossly inadequate to meet existing needs.
7. A program of direct treatment services must be implemented.
8. Through the concept for the treatment and care of handicapped children in the "mainstream" is well-founded and with much merit, it is a fact that such cannot be accomplished at many locations because of the lack of available local resources such as health care facilities and personnel.

In addition to the diagnostic and treatment planning services provided by the multidisciplinary outreach team,

supplemental diagnostic, evaluative, treatment planning, and limited treatment services were also provided by the University of New Mexico School of Medicine. A report of the services provided is attached. In excess of forty cases were referred to the School of Medicine during the reporting period. Though the services provided were of high quality and served to supplement and to a degree complement the services provided by the Project staff, it is our opinion that such an arrangement is not a practical or satisfactory alternative to providing the needed services. Some of the disadvantages of such an arrangement are as follows:

1. The overall costs including charges for professional services provided, administrative costs, transportaiton, housing, and other related costs, make this arrangement a very expensive one.
2. Acceptance of referrals and scheduling of admissions is within the total discretion of the School of Medicine. This affects the Project's ability to provide timely services and scheduling for it's patients.
3. Patients and their parents or escorts are transported to Albuquerque via commercial means of transportation and are lodged in local motels. Meals and local transportation also provided. There is demonstrated uneasiness on the part of the patients and parents in coming to a large city and being in a large medical setting. The lodging, meals, and transportation arrangements are not conducive to the proper care or accommodation of a handicapped child.
4. There is a lack of cultural awareness or orientation on the part of the service providers, a quality considered to be essential in the proper diagnosis of and treatment planning for an Indian child. The lack of knowledge of available local resources necessitates close involvement on the part of the Project staff in the development and implementation of treatment plans.

5. The lack of internal cooperation among the Departments of the University limits the services available to the Project under the contract. Services from other Departments must be acquired by separate contracts resulting in increased costs to the Project.

The Project has not been totally without problems. The following is a partial list of some of the problems or situations which have had a direct affect upon our ability to implement the project on a timely basis and to maintain its operation in the least restrictive environment:

1. Contracting requirements, policies and processes vary substantially between the two agencies. It is the recommendation of the Project directorship that all contracting be accomplished through the Bureau of Indan Affairs and that necessary arrangements be undertaken to include those contracts utilizing Indian Health Service funds allotted to the Indian Children's Program.

2. The Indian Health Service has refused to issue Government's driver's licenses to personnel employed under contract which the Indian Children's Program has with non-federal organizations, who provide supplementary services to the Project and work side-by-side with regular Indian Children's Program staff. Arrangements have been made with the Bureau of Indian Affairs to issue such licenses to all personnel in accordance with their policies and standards.

3. The space facilities originally allocated to the Indian Children's Program are totally inadequate to house the increased staff. A Request for Space (SF-81) for additional space was initiated in June 1979, and submitted through Indian Health Service channels. To date, there has been no response to the requested action. Staff is presently housed in severely overcrowded quarters.

4. The imposition of travel restrictions and mandatory mileage reduction has forced a curtailment of some field activities. No immediate solution is foreseeable, however, efforts at resolution will continue.

5. There is at present a difference in the service population of the Bureau of Indian Affairs-Indian Health Service. The Bureau of Indian Affairs has not clarified its exact service population and/or responsibilities for implementing P.L. 94-142. However, by combining what the Bureau of Indian Affairs presently feels is their jurisdiction and accommodating those who fall outside of that area within the jurisdiction of the Indian Health Service, we have been able to provide services to almost everyone who is referred. Those who cannot be served are being referred to other agencies.

6. A substantial portion of the funds being used for current operations are non-recurring funds which were made available at year-end leaving little, if any, flexibility to adapt to actual program needs or for inclusion as a resource in planning or developing future program plans and operations. The allocation of recurring funds (year-by-year funding) is essential if the program is to be maintained at a level which can be responsive to meeting needs, priorities, and commitments. Project directorship will, however, continue to seek and utilize supplemental sources of funding.

7. The personnel recruitment and appointment process has not been responsive to filling positions on a timely basis. Much of the problem has been due to a shortage or lack of qualified applicants for professional positions. The lack of a permanent position ceiling prevents us from offering the security of permanency of employment and has seriously affected our recruitment efforts.

8. The extent of the Bureau of Indian Affairs' (Project Co-Director) involvement in the Project has been on an interim or part-time basis. There is a demonstrated need for full-time involvement. The proposed revised organizational structure of the Indian Children's Program and the requested financial participation of the Bureau of Indian Affairs (See attached proposed budget), if approved, will facilitate such involvement.

9. The lack of demonstrated interest and response in the utilization of Indian Children's Program services by Bureau of Indian Affairs, and some Indian Health Service, field activities has been the cause of some concern. It is probable that this has resulted in the unnecessary duplication of effort and expenditure of funds. Considering the intent of this pilot project and the data or information sought, it would appear that Bureau of Indian Affairs and Indian Health Service offices and programs should be mandated to utilize the services provided through the pilot project.

10. There is currently within both agencies a lack of adequately defined service jurisdiction among closely related program activities. This has caused the problem of territoriality and accusations of infringement upon other servicing jurisdictions. It is possible that this problem could be eliminated through the process of reassessment and restatement of related program responsibilities and jurisdictions.

11. There has been a lack of consistent involvement from the Central Office staff of both agencies, and a continuous shift in people. As new individuals become involved, the direction, expectations, and requests change. Finalization and approval of a memorandum of agreement along with expected data requirements and issues to be addressed will solve this.

One of the purposes of this pilot project, as previously stated, is to enable the Bureau of Indian Affairs and the Indian Health Service to assess the need for a multidisciplinary medical/education complex to provide services to handicapped Indian children. It is our concensus that the experiences and findings to date warrant the continued development and design of a facility. There is an unmet need existent within the Indian communities which must be met if there is to be compliance of legal mandates and accomplishment of the inherent responsibilities and moral obligations which the Bureau of Indian Affairs and the Indian Health Service have to the Indian people. We feel that the information and data to be developed during the remaining period of the pilot project wili enable us to make a specific recommendation regarding a facility.

The past period of the pilot project has demonstrated that it is not only possible but that it is practical, feasible, and more economical for the Bureau of Indian Affairs and Indian Health Service to have a joint or shared relationship where there is commonality or related service responsibility. We, therefore, recommend that the Bureau of Indian Affairs and the Indian Health Service continue to operate a joint program designed to provide a combined medical-education diagnosis, evaluative, treatment planning, and treatment services for handicapped Indian children. Further, we strongly encourage both agencies to allocate adequate funding and personnel resources to permit the operation of a meaningful and successful program.

Acting Director Indian Children's Program	Co-Director Indian Children's Study Project

Attachments

JOINT BIA/IHS INDIAN CHILD STUDY PROJECT MEMORANDUM AGREEMENT

Under the agreement reached with Congressman Sidney R. Yates, Chairman, House Interior Appropriations Subcommittee, the Bureau of Indian Affairs and the Indian Health Service were to develop a cooperative pilot program to determine whether or not BIA/IHS should operate a joint program designed to provide a diagnostic, treatment planning, and treatment service for handicapped Indian children.

This pilot project would be designed and operated to permit an evaluation of BIA/IHS capacity for institutional cooperation on assisting BIA through a combined medical-education diagnosis, treatment planning, and treatment program for assessing educational needs of handicapped Indian children. This pilot project would enable both BIA and IHS to assess the need for a multidisciplinary medical/education complex to provide services to handicapped Indian children. Further, this pilot project is designed to expand outreach services currently provided by the IHS-Indian Children's Program (ICP).

This pilot project, to be known as the Indian Child Study Project, will be established in Albuquerque, New Mexico, and be operated under the following conditions.

1. The Indian Child Study Project will be a joint venture of BIA and IHS with co-equal emphasis given to the health as well as the educational welfare of the child and parents.
2. Medical and educational diagnostic and treatment planning services will be provided by the Project through existing local services under contract or through direct services provided or arranged by IHS or BIA as appropriate, consistent with the concept of services to handicapped children in the least restrictive environment.

3. Indian children suspected of having medically and/or educationally handicapping conditions affecting development are to be referred to the Project for a comprehensive inter-disciplinary evaluation and child study either locally by the ICP Outreach Team or by the UNM School of Medicine, if conditions warrant. Referring sources could be parents, BIA schools, social service units, and local IHS units.
4. The geographic region to be utilized in this pilot project would be the Albuquerque, Navajo, and Phoenix areas. Referrals from outside this immediate region would be subject to availability of space, time and program capacity.
5. Diagnostic facilities will be provided by the BIA and/or IHS as appropriate under the conditions.
6. Transportation and housing for the child and parents will be provided through Project.
7. Results of the examination with recommendations will be discussed with the child's parents, school, and teacher and implemented in accordance with prescribed treatment plans or as may be modified by mutual agreement of concerned parties to coincide with the availability of local resources or lack thereof.
8. A report will be sent to appropriate local BIA and IHS resources for implementation and follow-up.
9. BIA-Office of Indian Education Programs and IHS will each designate a representative to assume joint responsibility for operating the project as co-directors. Each will be given full and complete program and administrative authorities necessary to carry out such responsibility. Both directors shall report to the Office of Indian Education Programs and the Director, Indian Health Services.

10. Both BIA and/or IHS will cooperate to provide contracting, fiscal, and personnel support services when and wherever necessary as expeditiously as possible.

11. The staff of the Indian Child Study Project will prepare a report covering the first 90 days of operation of the Project. It is mutually agreed that the start of the Project shall be November 1, 1979. This report is to cover the number of children reviewed, the results of the medical/educational diagnosis, and the follow-up recommendations. The report should also address the development of the Project, the relationship between IHS/BIA, and the projected prospects for institutional cooperation and its implications for the BIA handicapped program.

12. A more complete and detailed report is to be submitted by November 1, 1980, covering the same issue[s] as in the required 90 days report. In addition, this report is to include a final recommendation as to the need for establishing a BIA/IHS medical/educational complex to serve handicapped Indian children either in one geograhical setting or at a number of centers located throughout the BIA/IHS jurisdictional service area or not at all. In addition, recommendations in respect to the need for continuing a joint Outreach Program to provide diagnostic service, treatment planning, treatment, consultation, technical assistance and training will be provided.

13. Costs: Costs for the pilot project are to be funded by both the BIA and IHS as previously determined. The results of the pilot project shall not preclude the IHS-ICP from continuing its program of services for mentally and emotionally disturbed and handicapped Indian children.

14. The period of this pilot project shall be for one year, November 1, 1979, to November 1, 1980.

Signed:

/s/ [Illegible]
Deputy Assistant Secretary
Indian Affairs
U. S. Department of the Interior

2/21/80
Date

/s/ [Illegible]
Administrator
Health Services Administration
U. S. Department of Health,
Education and Welfare

2/20/80
Date

INDIAN CHILDREN'S PROGRAM

Office of Mental Health Programs
Indian Children's Program
March 14, 1980

Indian Children's Program

In 1976, the Congress of the United States enacted PL 94-437, the Indian Health Care Improvement Act. The Act declared that it is the policy of the United States, in the fulfillment of its special responsibilities and legal obligations to the American Indian people, to meet the national goal of providing the highest possible health status to Indians and to provide existing Indian health services with all resources necessary to effect that policy.

Title II, Section 201, Sub-section c, of this Act authorizes appropriations for the development of children's residential, diagnostic and treatment center(s) within the Mental Health Programs of the Indian Health Service. The Indian Children's Program is a response to this critical area of need and Congressional mandate. This Program is an integral part of the Mental Health Programs of the Indian Health Service and has the overall responsibility for coordination of effort in developing, providing and evaluating mental health services for children.

In carrying out this responsibility, one long neglected or overlooked area of specific service need was identified early in the development of the program as a result of another piece of legislation, PL 94-142, commonly referred to as the "Education of the Handicapped Act." Three of the problem categories identified in this Act, mental retardation, severely learning disabled, and severely emotionally disturbed, clearly require attention from the Program. The Indian Children's Program, however takes the position, advocated by the Joint Commission on the Mental Health of Children, that in child advocacy, one cannot separate mental health from physical health and has identified services to handicapped Indian children as a major focus of their effort.

It is estimated that there are in excess of 35,000 Indian persons under 21 years of age who have some form of handicapping condition. While not all these conditions

require the services of the Indian Children's Program, it is estimated that in the three categories noted above there are in excess of 12,000 Indian children under age 18 with problems of sufficient severity to require specialty diagnostic and treatment services.

In response to meeting this area of need and in complying with the Congressional mandate of both Acts, the Indian Children's Program responsibilities are focused on the provision of diagnostic, evaluative and treatment planning services to handicapped Indian children as a prerequisite to the proper treatment and care of these children.

Prior to the inception of the Indian Children's Program, services to handicapped children were provided on a "hit or miss" and "as can" basis by the staff of local Indian Health Service units, and in limited instances, tribal health care organizations. Ability to provide services to handicapped children was further affected by inattention to the need for such services or assignment of low priority by community or civic leaders, and in many instances, a cultural concept by Indian parents that the birth of a handicapped child was a form of punishment upon a parent or set of parents for past wrongs committed, and that such punishment had to be endured.

During the developmental period September 1978 through September 1979, with a full-time staff consisting of a Clinical Psychologist, a Physical Therapist, a Social Worker, and the part-time services of a Speech Therapist, an Expressive Arts Therapist, an Educational Diagnostician, and an Occupational Therapist, the following services were provided:

Diagnostic Evaluations/Assessments	422
Case Revews and Client Consultations	192
Program Assistance (Multidisciplinary and Mental Health)	153
Training (Sessions)	83

During this period these services were provided to a limited number of programs located on the Navajo Reservation and the Pueblos of Zuni, Laguna, Acoma, Jemez, and Santo Domingo.

The diagnostic evaluations and assessments were performed for children who had been referred from a variety of sources such as schools, clinics, parents, etc. The types of evaluations were psychological, psychoeducational, speech, occupational therapy, physical therapy, medical, psychiatric, and vocational rehabilitation depending on the needs of the referred child. Each case was then staffed and reviewed in the community by local health care providers who would be involved in the child's follow-up care. The parents and/or guardian were also involved.

Treatment planning included input from the family and local care providers. If specific treatment was required and was not available locally, someone in the family or the community was trained to provide the treatment when feasible. Periodic follow-up consultation was available from the ICP staff.

The case reviews conducted were of cases involving children with special problems. The reviews were made by a multidisciplinary team consisting of a Social Worker, Psychologist, Occupational Therapist, Physical Therapist, Arts Therapist, Speech Therapist, and an Educational Diagnostician. The cases were reviewed collectively to identify the child's specific problem areas and to provide recommendation to meet their special service needs.

The program assistance provided included assistance in proposal writing, development of new programs, extension of base programs, and development of community based resources to meet the special unmet needs of children within the community. Specifically, these efforts resulted in the development of first offender programs, alternative schools, and similar programs.

The training provided included instruction on the techniques and skills used in the care of handicapped children and included such topics as feeding techniques with developmentally disabled children and art techniques with handicapped children. The recipients of these instructions included local IHS personnel, special education personnel, tribal CHR's and other local health care providers.

The treatment provided was limited by staff size and availability of local resources. Treatment services are provided to the child and/or family and included individual child evaluations, therapy, individual and group counselling, and any services which entailed one to one interaction with the child, family, or staff member involved with the child.

Indian Child Study Project:

PL 94-142 mandates the evaluation of a child on a holistic basis, necessitating a multidisciplined diagnosis and thereby creating an environment for a conjoint effort between the Bureau of Indian Affairs and the Indian Health Service.

In the Fall of 1979, the IHS-Indian Children's Program, at the encouragement of Congressman Sidney Yates, was joined by the Bureau of Indian Affairs in a cooperative Project. The cooperative Project was to be designed to accomplish the following:

1. Determine whether or not the Bureau of Indian Affairs and the Indian Health Service could operate a joint program designed to provide diagnostic, treatment planning, and treatment services for handicapped Indian children, and

2. Develop a position on the need of a multidisciplinary medical/education facility to provide these services.

In addition to appointing a part-time Co-Director of the Project, the Bureau of Indian Affairs allocated $350,000

of year-end funds toward implementing the concept which was subsequently articulated in a formal interagency agreement, a copy of which is attached. The funds provided by the BIA served to supplement the existing Indian Children's Program by facilitating the employment of additional personnel including Educational Diagnosticians, Speech Therapists, a Developmental Psychologist, a Vocational Rehabilitation Therapist, a Recreational Therapist, a Physical Therapist, and an Occupational Therapist. With the additional staff the services of the Indian Children's Program were expanded by: (1) increasing the number of evaluations and consultations which could be conducted; (2) increasing the number of training sessions and special clinics which could be conducted; (3) permitting a wider range of representation of disciplines on the outreach staff; and (4) by increasing follow-up capability.

NIMH—Most-In-Need Program (MIN):

The Indian Children's Program has also been assisted in its efforts by the National Institute of Mental Health (NIMH) by making funds available through the Most-In-Need Prorgram (MIN). These funds have been earmarked for use in the employment of a Developmental Pediatrician, Clinical Psychologist, and a Social Worker. The personnel hired under the MIN program work directly with the multidisciplinary outreach teams.

BCMC-UNM:

Since the outreach team does not have a full complement of specialized disciplines represented on the team, and due to lack of appropriate facilities, at many locations it has been necessary to acquire some diagnostic and treatment services from other resources. A contract between the IHS-Indian Children's Program and the University of New Mexico School of Medicine was entered into. The

School of Medicine provides supplemental diagnostic, evaluative, treatment planning, and limited treatment services.

Indian children, accompanied by their parents or an escort, are brought to Albuquerque, housed in a local motel, and diagnosed or treated on either an inpatient or outpatient basis by the UNM School of Medicine. The outreach staff of the Indian Children's Program is involved in the staffing of each case, the development of a treatment plan, and the implementation and follow-up of the plan. This arrangement has served to make more specialized and a wider range of diagnostic services available to the Indian Children's Program. With the current staff and funding limitiations, it was decided to limit the primary catchment area to two states encompassing four IHS Areas, Albuquerque, Navajo, Phoenix and Tucson.

During the 90 day period November 1, 1979 to February 1, 1980, Indian Children's Program staff had on site contact with over 100 separate Tribal programs serving 20 Tribes. Table II, Appendix, lists these programs and tribes. Services provided to these programs during this period were categorized in the following fashion:

Diagnostic Evaluations/Assessments	197
Case Reviews and Client Consultations	252
Program Assistance (multidisciplinary and Mental Health)	17
Training (Sessions)	29 (for 696 people)

Diagnostic evaluations/assessments and case reviews/client consultations were provided for 246 patients. A breakdown by primary problem and age group of these 246 patients is included as Table I of the appendix. After appropriate evaluations, it was determined that 36 of the 246 patients seen during this period did not require further action.

The remaining 210 have continued to receive services from the program. 43 had problems of sufficient complexity to require more detailed workups at UNM. To date 14 of these have been further evaluated and appropriate follow-up initiated.

At the end of this 90 day period there was a backlog of 204 evaluations and assessments and 24 case reviews scheduled. During the month of February 122 of the evaluations and assessments were completed and all 24 of the case reviews were carried out.

Extrapolating the 90 day workload, by categories, to one year to compare with the previous year we find the following:

	FY-79	FY-80 (extrapolated)
Diagnostic Evaluations/Assessments	422	788
Case Reviews and Client Consultations	192	1008
Program Assistance (Multidisciplinary and Mental Health)	153	68
Training (Sessions)	83 to 2,414	116 to 2,784

Workload information from the month of Februar[illegible] 1980 is consistent with these projections. Approximately [illegible] (210 of 246) of the patients seen during the 90 day pe[illegible]d require some level of follow-up care or attention, by at least one member of the ICP staff. Extrapolating the patients served would mean that in excess of 850 patients would be receiving services by the end of the year, with the program staffed at current level. This would approach the limits of the capacity of the program to continue to provide quality services.

In developing an effective system, attention has been given to the need for developing a strong referral network,

backed up by first class diagnostic and evaluative services with access to specialty services available through existing medical school programs, pragmatic and practical inter-disciplinary case planning, and on-going systematic follow-up in case management to insure that recommendations are integrated into the overall care of the patient and that these are actions indeed having the desired effect.

In addition to the outreach services provided by the Indian Children's Program, the following are other activities also administered by the Program.

1. *SOMPA Project*

   There has been continuous concern that many of the testing instruments and methods utilized to test the intelligence or learning capability of Indian children are not valid because such instruments and methods are not culturally oriented or there are no existing culturally standardized testing norms. The IHS and the BIA have jointly undertaken a project referred to as the SOMPA (System of Multicultural Pluralistic Assessment) Project for the conducting of necessary research and testing to determine the possibility or practicality of establishing culturally oriented testing norms. The Project is underway at the Pueblo of Laguna and upon completion will be moved to the Pueblo of Zuni and eventually to the Navajo Reservation.

   Socioculturally appropriate norms have been established for Blacks and Hispanic children resulting in a decrease in the number of these children being labeled as psychologically or intellectually deviant. In this project a determination will be made as to whether socioculturally appropriate norms can be established for Indian children from the three tribes. The goals are to increase the validity and reliability of psychological evaluations of Indian children and thus decrease

the number of "false positives", i.e., Indian children incorrectly identified as psychologically maladjusted and intellectually deficient when standard instruments and norms are completed. Random samples of children from both sexes at each age level between 6 and 11 will be selected from each tribe.

Parents/guardians will also be interviewed. It will be determined whether it will be necessary to establish norms for each tribe. Completion of this project will make possible compliance with PL 94-142, a key requirement.

2. *Fetal Alcohol Syndrome Project*

   The purpose of this Project is to improve and broaden the scope of services presently provided to the Indian child and its mother. The Project, which has been operational since November 1979, provides for the identification, referral, diagnosis, and treatment of a child with fetal alcohol syndrome and its mother. It also provides for a broad preventive effort through increasing individual, family and community awareness of fetal alcohol syndrome. The Project is presently limited to Navajo and Albuquerque Areas of the IHS. We have received requests from other locations outside of these areas, however, without increased funding and staffing, it is not possible to expand our present scope of services.

   Currently, clinical training sessions on Fetal Alcohol Syndrome have been held at all IHS Service Units in the Navajo and Albuquerque Areas. Selected physicians, nurses, and outreach workers have received two hours of intense instruction in Fetal Alcohol Syndrome diagnosis. In the spring months screening clinics for the diagnosis of F.A.S. affected children will be held by consultant pediatric dysmorphologists. From the clinics children will be referred to appropriate health care

facilities for needed therapy and for treatment. The benefits of the program are thus threefold: 1) the children will receive needed treatment; and 2) the project will be able to establish data regarding the prevalence of this problem within the Albuquerque and Navajo Areas; 3) educational materials and preventive efforts will be developed.

3. *Convulsive Disorders Study Project*

The goals of this project are:

1) To determine the prevalence and patterning of epilepsy in several Indian populations.

2) To assess follow-up treatment care and start case registers.

3) To assess the differences in the psychiatric problems of epileptic patients.

4) To assess the differences in the psychiatric problems of epileptic patients as they may vary between tribes.

5) To make recommendations concerning education and follow-up activities suitable for each type of community studied.

The study has been completed at the Pueblo of Zuni and is currently underway among the Tewa Pueblos in New Mexico. A copy of the Zuni report is attached.

Funding for this project has been made available from the Indian Children's Program budget. It, however, appears that the project cannot be funded beyond the completion of the Tewa Pueblos study because of the insufficient resources of the ICP. The study is a worthwhile project which addresses an area which has long been neglected and should certainly be continued. The benefits derived from this project are twofold: 1) persons with epilepsy are identified; and 2) treatment and follow-up care can then be initiated.

SUMMARY/ASSESSMENT

The Indian Children's program, with assistance made available by the Bureau of Indian Affairs and the National Institute of Mental Health, has expanded its quality and quantity of services significantly. Caution must, however, be exercised in the further expansion of services because three-fourths of the total present ICP clinical staff of eleven are employed under contracts scheduled to expire at the end of the current fiscal year.

Without a significant increase in the allocation of funds and personnel ceiling, it will not be possible to meet existing program needs and to expand the service area. Without the benefit of diagnosis and evaluation of a child as a "whole", which can best be accomplished in a residential setting, or on an outreach basis in lieu thereof, handicapped Indian Children will either not be diagnosed and evaluated or suffer the consequences of inadequate diagnosis which most often results in the mislabeling of a child. Because most Indian communities do not now have nor can they realistically support a permanent multidisciplined clinical team, the services of an outreach team or a residential facility are the most viable alternatives.

PL 94-142 and the regulations implementing such Act, mandates that the evaluation procedure of a child must include a holistic approach utilizing a multidisciplinary team. We submit that the joint project between the Bureau of Indian Affairs and the Indian Health Service has demonstrated that it is a practical and economically feasible method by which the two agencies can fulfill their respective legal mandates in providing diagnostic and treatment planning services to handicapped Indian children.

There are a number of factors which contribute to the difficulties or problems encountered in the development of or the providing of services to handicapped Indian children and their families. Among these factors are:

1. Difficulties with providing regularly scheduled or fairly constant services to a large geographic area consisting of widely dispersed, isolated and small rural communities. The Navajo Reservation alone consists of almost 14,000,000 acres with a population of over 100,000 persons.
2. Inability of most communities to support financially, and on the basis of full-time need, a multidisciplinary professional staff as required to provide necessary diagnostic and treatment services.
3. Extreme difficulty in recruiting and retaining qualified professional personel willing to work under the demanding conditions of the job. Members of the outreach staff spend approximately 75% of their work week doing field work and spending on the average of two days away from home each week. The hours of work are long and irregular.
4. The distances that patients must travel to the nearest major medical facility make treatment planning and arranging for treatment services extremely difficult, if not possible, where specialized or major services are required.

The contract with the UNM School of Medicine has served to make supplemental diagnostic services available. This arrangement is, however, not without its disadvantages including the following:

1. The overall costs including charges for professional services, administrative costs, transportation, housing, and other related costs makes this arrangement a very expensive one. At the very minimum, the charge per child for diagnostic developmental evaluation without additional medical services is $1,236. Average charges in a residential facility such as the Kennedy Institute in Baltimore is $350 per day with an average stay of two days per child.

2. Acceptance of referrals and scheduling of admissions is within the total discretion of the School of Medicine. This has directly affected the ICP's ability to provide timely services and on-the-spot scheduling for its patients.
3. Patients and their parents or escorts are transported to Albuquerque via commercial means of transportation and are lodged in local hotels. Meals and local transportation are also provided. The cost for these services is in addition to the charges for diagnostic services. There is demonstrated uneasiness on the part of the patient and the parent in coming to a large city and being in a large medical setting. The lodging, meals and transportation arrangement which can be made are not conductive to the proper care or accommodation of a handicapped child.
4. There is a lack of cultural awareness or orientation on the part of the service providers, a quality considered to be essential in the proper diagnosis of and treatment planning for an Indian child. This quality has developed within the staff of the Indian Children's Program. The lack of knowledge by the service providers of available local resources necessitates close involvement on the part of the Indian Children's Program staff in the development and implementation of treatment plans.
5. The lack of internal cooperation among the Departments of the University limits the services available to the Program under the contract. Services from other Departments must be acquired by separate contracts resulting in increased costs to the Program.

ILLUSTRATIVE CASES

Perhaps the following cases will illustrate the kinds of problems and the need for the multidisciplinary approach being taken by the ICP.

"A 7 year-old girl was referred to the occupational and physical therapists of the Indian Children's Program by the Elementary School staff. This child had a history of enuresis and behavior problems, a poor family situation, learning disabilities, and some minor sensorimotor problems. This child was evaluated by the physical and occupational therapists, and specific problems were found in the sensorimotor and motor planning areas. A remediation (therapy) program was designed and taught to the school staff. School problems seemed to be increasing including teacher-student relationships and profuse wetting. A referral was then made by the therapists to the child physchologist of the Indian Children's Program and an interdisciplinary case review was planned.

Further information indicated that the enuresis exacerbated by the presence of a chronic bladder problem which was treated upon referral to the local IHS clinic.

The physchologist saw this child and reported that the child was continuously verbally and emotionally abused by her father who repeatedly denied any relationship to the child. These incidents were well-known to the school officials but they had not intervened due to fears of antagonizing the father. However, the school personnel had difficulty tolerating this child's presence not only because of the smell related to the enuresis but also because of her clinging, subservient, attitude. They often sent the child home, knowing the probability and frequency of abuse, or allowed the child to wander the school hallways. Then the psychologist from the Indian Children's Program initially intervened, the staff spoke about this child with overt angry, hostility, and frustration, saying that they could not deal with this child and wanted her sent away. They admitted to some mild abuse themselves: sitting the child on the toilet for 30 minutes, simultaneously criticizing her for her poor bladder control. Further, they had refused her participation in school parties

or outings. A staffing was held with the Indian Children's Program's Psychologist which centered on support and permission to feel angry and frustration. Explicit recommendations were made by Indian Children's Program including individual therapy for the child, supportive counseling/consultation by Indian Children's Program for the staff, and a behavioral program for increasing the child's acceptance of the bathroom facilities. Family counseling services were recruited by Indian Children's Program from the BIA social services. Presently, this child has ceased her wetting, is worked with individually by the staff, and is an active, and welcomed participant in all school functions. Her mother is receiving supportive counseling from the school counselor while the father is no longer abusing the child. The school staff appear elated and relieved. It is likely that Indian Children's Program intervention saved this child from institutionalization and the school staff from the guilt of not having been able to succeed with this child."

This is but one example of the type of cases in which the staff of the Indian Children's Program has become involved. It is difficult to predict what may have happened to the child had there not been intervention on the part of the ICP. The end results is that the child has basically overcome her medical problem and has become an active and welcomed member of her peer, family, and tribal group. Further, her father and mother have also benefited by receiving personal help in overcoming their problems.

"This 18 year-old girl resided in a vocational shelter after being expelled from four other shelters. The staff at this shelter complained that they too could not deal with her behavior. The local tribal court concurred and requested committment to the state mental hospital.

This girl had a history of various suicidal acts. She had attempted to hang herself, pinched herself in the neck so

that large bruises resulted, cut her lower arms with a razor blade resulting in a series of precise small cuts up and down the sides of her arms. Further, she broke windows, sexually molested staff and other clients. She had previously been forced to abort an illegitimate child and was beaten by her mother. Her mother and brothers were reported to have forced her to clean the hogan, fix the food, herd the sheep, and continuously beat her.

Prior to expelling her from the residential shelter, the staff consulted the psychologist and social worker from the Indian Children's Program. The ICP staff evaluated the client and made specific recommendations about problems to be addressed in individual sessions with the client to assist her in learning new ways to more appropriately interact with staff and clients. During subsequent staffings the staff noted significant improvement in her behavior a total absence of suicidal gestures, improved work performance, and less sexual acting out. The staff were willing to keep this woman in the shelter but felt that long term placement would be more appropriate. Indian Children's Program recruited the help of B.I.A. social services, and the vocational rehabilitation agency in designing long term treatment plans while ICP staff continued to consult with the staff and assist them in counseling this girl."

"This 33 year-old woman and her 10 year-old son came to the attention of ICP due to abuse by the 10 year-old of his mother and the mother's inability to control the child. The mother was previously hospitalized for a psychotic reaction and had a history of treating her child as an infant: i.e., having great difficulty separating from her child and caring for her child's growing needs. She would buy multiple bicycles instead of buying food or paying the rent. The staff at the residential shelter was unable to deal with her hallucinations and her intrusions on her son during school hours. They requested that she leave

the facility. She lived for a while in a nearby community but was unable to maintain a job since she frequently left work to visit her son at school. At that time, she was receiving counsel from a local mental health team and assistance from B.I.A. social services. Without money and with growing bewilderment on the part of B.I.A. social services, she returned to the residential shelter while her son was placed in an adjacent boarding school. The staff, though, once again complained about her lack of work incentive and her constant verbalizations about her worries about the whereabouts and health of her child. The staff brought the case to the attention of the psychologist and social worker from I.C.P. At the original staffing, it was agreed that an evaluation of the son was needed as well as an evaluation of the relationship between the son and his mother. The evaluation resulted in multiple suggestions presented to a staffing including the following participants: psychologist, social worker, vocational rehabilitation specialist, (all from I.C.P.), B.I.A. social services, a vocational rehabilitation person from the Tribe, a counsel from the schools, the staff from the residential shelter, and paraprofessional counselors from the local mental health team.

The staffing resulted in cooperation between I.H.S. vocational rehabilitation representative and B.I.A. social service worker in planning for separate long term placements for the woman and her son, individual counseling for mother by a Navajo counselor from the mental health center, support consultation of the staff from the residential shelter by I.C.P., counseling of the boy by the school counselor, and coordination/consultation by I.C.P. Previously, this case was a long standing one which continued to frustrate all the participants. Presently, the mother is working with the staff and allowing her son to attend school and to begin to develop emotionally, socially, and cognitively."

Realizing the lack of services for handicapped Indian children, one cannot help but be concerned about the hundreds of children like these children who have never had and may never have the benefit of services of a program developed especially for them.

The Indian Children's Program, as evidenced by this report, has accepted the challenge of developing, implementing, and providing, or assuring the provision of meaningful and much needed services for handicapped children, their families, and their communities. However, we have only "scratched the surface". With the allocation of adequate permanent funding, employment ceiling, and support the ICP has the potential and desire for continued growth and expansion.

EXHIBIT D

UNDUPLICATED COUNT OF PATIENT REFERRALS BY PROBLEM AND AGE GROUP SEEN BY INDIAN CHILDREN'S PROGRAM

	Nov. 1, 1979 thru Jan. 30, 1980							February 1980						
DISABILITY [1]	0-2	3-5	6-12	13-18	19	Total	% of Total	0-2	3-5	6-12	13-18	19	Total	% of Total
Deaf					1	1	1						0	
Deaf/Blind						0							0	
Hard Hearing	1	1	1			3	1			1			1	1
Mentally Retarded	5	15	16	13	11	60	24			7	5	2	14	17
Multi-Handicap	6	13	17	13	8	57	23	1	2	4	2	1	10	12
Ortho Impaired	1	3	5	4	2	15	6		2	4	4	1	11	13
Other Health	4	4	2	2		12	5						0	
Seriously Emotion. Dist.			8	13	5	26	11	1	2	12	7	3	25	30
Specific Learn. Dis.		3	13	5	1	22	9		1	3	3		7	8
Speech Impaired			6	1	1	11	4		4				4	5
Visual Handicap	2	1				3	1						0	
Non Handicap [2]	2	8	20	5	1	36	15		2	8	1		11	13
TOTAL	21	51	88	56	30	246		2	13	39	22	7	83	99

[1] For purposes of this report, the categories of disabilities are those defined in 121a.5 of PL 94-142. FR 42-163, 1977.

[2] This category represents patients who were referred for evaluation, evaluated and a determination made that their problems were not of sufficient severity to require further action by Indian Children's Program.

EXHIBIT E

INDIAN CHILDREN'S PROGRAM
MARCH 1980-FEBRUARY 1981

	Diagnostic Assessment	Case Reviews	Program T/A	Direct Services	Training Session/People	
Speech	299	144	7	11	30	318
Educational Diag	255	250			5	100
O.T.	238	69	34	44	30	299
P.T.	255	49	16		22	262
Art		10	1	629	43	411
Medical	163	63	23	30	6	110
Voc. Ed.	138	236	30	24		
Therapy				48		
Social Service		205	46	4	4	60
Psychological	90	228	40	102	43	728
Neurological	8	8				
Psychiatric	107					
Medical School	124	162				
Convulsive Disorders	200	245	5	800	15	400
FAS	134	134			94	3199
	2011	1803	202	1692	292	5947

Served 213 programs on 47 Reservations.

Do Not know total # of children served just services offered.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
PUBLIC HEALTH SERVICE
HEALTH SERVICES ADMINISTRATION

Indian Children's Program
Indian Health Service
2401 12th St. N.W.
Albuquerque, New Mexico

07 Apr. 1981

MEMORANDUM

To: Assistant Secretary for Indian Affairs
Director, Indian Health Service

From: Director, Indian Children's Program
Co-Director, Indian Child Study Project

Subject: Yearly Report—Indian Child Study Project

In June 1979, in conjunction with directives from Congress, The Bureau of Indian Affairs and the Indian Health Service entered into a cooperative pilot project to determine the feasibility of both agencies jointly operating a project to provide diagnosis, treatment planning, and treatment services for handicapped children; and to develop a position in the need of a multidisciplinary medical/education facility to provide these services. This report covers the results of six months of planning and implementation, and the next year of services.

On September 13, 1979, the Bureau of Indian Affairs allocated $350,000 of year end money to the Albuquerque Area Office. This money was utilized through contracts, to support and supplement the existing Indian Health Service-Indian Children's Program with:

A. Additional Staff

2 Educational Diagnostician
1 Art Diagnostician/Therapist
1 ½ Speech Pathologist
1 Developmental Psychologist
1 Vocational/Rehabilitation Therapist
1 Physical Therapist
1 Occupational Therapist
1 Recreational Therapist
Clerical Support

B. Funds for related costs of transportation and lodging of patient children and their parents brought to Albuquerque, New Mexico for diagnosis and evaluation through the University of New Mexico School of Medicine.

C. Funds for initiation of the SOMPA Project.

The Indian Health Service-Indian Children's Program, also received an allotment of year-end funds which were obligated via contracts to the University of New Mexico School of Medicine to provide diagnostic, evaluative, treatment planning, and limited treatment services for handicapped children referred by the Indian Children's Program on either an inpatient or outpatient basis. These services were intended to be utilized where such services were not available locally or could not be provided by the staff of the Indian Children's Program or other local resources. In addition, the Indian Children's Program made available to the study project its regular program staff consisting of the following disciplines:

A. Clinical Psychologist
Social Worker
Occupational Therapist
Speech Therapist
Child Psychiatrist

In July 1980, the Indian Children's Program submitted a LEA (Local Education Agency) application for P.L. 94-142 funds to the Bureau of Indian Affairs. This was approved for $127,521 to provide the following support:

A. 2 Educational Diagnosticians
1 ½ Speech Pathologist
1 Physical Therapist
1 Occupational Therapist
1 Recreational Therapist
2 Clerical Support

The funds were year-end funds and contracts were utilized for expenditures during the period of September 1, 1980 through September 30, 1981. The Albuquerque Area was designated as the support group for this project and Ms. Ann Crawley, of the Albuquerque Area Education Division was appointed Co-Director of the Indian Child Study Project. The Indian Health Service increased the number of permanent positions and through year-end funds contracted for additional personnel and support. This included:

A. 1 Art Diagnostician
1 Social Work Associate
1 Vocational Educational Specialist
2 Developmental Psychologist
1 Developmental Pediatrician

Over this report period, the increase in staff has resulted in an increase in capability to provide services. Attached is a detailed report of the services rendered during the reporting period including information as to the number and types of services provided and the findings. The initial service area was limited to the Albuquerque and Navajo Areas, and the Hopi Reservation within the Phoenix Area. As the service capability was increased, the referrals also increased in a disportionate ratio. Recently we experienced a large increase in referrals from the Phoenix Area. Arrangements were made for limited

services to the Papago and Pima Reservations. Recent requests have been received from groups in Wisconsin, Oklahoma, and Nevada for services and assistance in the development of multidisciplinary diagnostic team.

The conclusions which can be drawn from this reporting period are as follows:

1. There is a tremendous unmet need for diagnostic and evaluation services for all Indian children and a tremendous unmet need for treatment planning, consultative, treatment and follow-up services for handicapped children and their families.
2. There is a serious shortage, a lack of available local resources to meet such needs.
3. The multidisciplinary team approach is a viable means of partially meeting such needs.
4. Replication of the multidisciplinary outreach team at other site locations is warranted and would result in enhancement of access to services and the beneficial use of available funds.
5. The current level of permanent funding and program staffing is grossly inadequate to meet existing needs and the growing demands for services.
6. A program of direct treatment services must be implemented.
7. The current level of permanent (recurring) funding and position allocation is grossly inadequate to meet existing needs.
8. The multidisciplinary outreach team approach is a workable and practical approach to a cooperative effort of providing such services to Indian children by the Indian Health Service and the Bureau of Indian Affairs. It not only makes available specialized personnel to provide comprehensive services within the least restrictive environment, but permits both agencies a means of meeting the legal mandates of P.L. 94-142 and P.L. 94-437.
9. A residential multidisciplinary medical facility with educational support is needed to provide services where local resources are totally non-existant or severely limited, and where the handicapped conditions of children are so severe or such that the services of an outreach team would be inadequate.
10. There is a severe shortage of culturally-oriented, reservation based residential treatment facilities for the severely or profoundly handicapped Indian Children.

The multidisciplinary outreach approach, as stated, is a viable and responsive means or method of providing services to Indian children within a reservation or rural setting. It may be viewed by some as being an expensive way of providing services. However, one must recognize that the seeming high cost must be attributed to the geographic remoteness of communities served; the cost of acquisition of professional services including professional staff salaries; high program operation costs due to increased cost of transportation, lodging and related expenses. It should also be noted that the children seen by a team of this type are frequently children with multiple handicaps who need a multiple, comprehensive, integrative approach to the diagnosis and treatment and rehabilitation of their disorders. An early comprehensive intervention may appear expensive initially, but if rehabilitation can be initiated earlier and can carry the child farther than has been the case in the past, then, of course, the long term costs of the care for the child are reduced. It should also be remembered that one of the other functions of the multidisciplinary outreach team is to provide training and consultative support to community based programs to improve the local capability to

support handicapped children to their own communities. Frequently, no other professionals are available to provide this kind of service on an ongoing, continuous basis. In the long term, costs for the care and maintenance of children are reduced.

The Indian Children's Program through the Indian Child Study Project implemented the following action items as a result of the first report and its findings:

1. The Bureau of Indian Affairs contracted for a portion of the outreach services utilizing both BIA and IHS funds. The cooperation, resourcefulness and knowledge of BIA administrative personnel and in particular the contracting officer, has streamlined the acquisition of administrative services for contract personnel and has enhanced the responsiveness of the Indian Children's Program in providing its services.
2. Internal operating processes and space arrangements were developed and implemented in a manner so as to promote better staff utilization, coordination of services to communities, as excellent line of communication, and the most economical and beneficial use of funds and resource made available to the Program.
3. The service population of the Indian Children's Program was determined to be a combination of those eligible from both agencies thereby accomodating all Indian children.
4. Established regularly scheduled monthly screening clinics at several locations utilizing IHS and community health clinics.

The Project has not been totally without problems. The following is a partial list of some of the problems or situations which have had a direct affect upon our ability to implement the project on a timely basis and to maintain its operation in the least restrictive environment:

1. The imposition of travel restrictions and mandatory mileage reduction has forced a curtailment of some field activities. No immediate solution is foreseeable, however, efforts at resolution will continue.
2. A substantial portion of the funds being used for current operations are non-recurring funds which were made available at year end leaving little, if any, flexibility to adapt to actual program needs or for inclusion as a resource in planning or developing future program plans and operations. The allocation of recurring funds (year-by-year funding) is essential if the program is to be maintained at a level which can be responsive to meeting needs, priorities, and commitments.
3. The extent of the Bureau of Indian Affairs' (Project Co-Director) involvement in the Project has been on an interim or part-time basis. There is a demonstrated need [f]or full-time involvement. The proposed revised organizational structure of the Indian Children's Program and the requested financial participation and permanent ceiling request of the Bureau of Indian Affairs, (See attachment) if approved, will facilitate such involvement.

There is currently within both agencies a lack of adequately defined service jurisdiction among closely related program activities. This exists primarily at the headquarter level of both agencies as evidenced by the problems of territoriality and accusations of infringement upon the other's servicing jurisdiction. This has resulted in the development of the lack of clearly defined service responsibilities and jurisdiction at the local and field level.

There has been a lack of consistent involvement from the Central Office staff of both agencies, and a continuous shift in people. As new individuals become involved,

the direction, expectations, and requests change. Finalization and approval of a long term memorandum of agreement along with expected data requirements and issues to be addressed will solve this.

The lack of sound, reliable, and responsive administrative services, namely contracting and personnel, within the Indian Health Service at all levels has seriously hampered program operations. The Program directorship must devote an inordinate amount of time in pursuit of administrative services to the neglect of community relations and program operations.

The past period of the pilot project has demonstrated that it is not only possible but that [it] is practical, feasible, and more economical for the Bureau of Indian Affairs and Indian Health Service to have a joint or shared relationship where there is commonality or related service responsibility. We, therefore, recommend that the Bureau of Indian Affairs and the Indian Health Service:

1. Continue to operate a joint program designed to provide a combined medical-education diagnosis, evaluative, treatment planning, consultation and treatment services for handicapped Indian children.
2. Replicate the multidisciplinary team concept at other site locations.
3. Allocate adequate funding and personnel resources to permit the operation of a meaningful and successful program.
4. Proceed with necessary action for the planning and design of a residential diagnostic, treatment planning and treatment center.

Director, ICP

Co-Director, Indian Child Study Project

DEPARTMENT OF HEALTH AND HUMAN SERVICES

17 Jul. 1981

MCH Program Coordinator
Indian Health Service

Comments and Recommendations—
Indian Childrens Program

H.C. Townsley, M.D.
Director Office of Mental Health Programs
Thru: Director, Division of Program Operations ——
Chief, Medical Officer ——

As per our agreement here are my thoughts and conclusions about the present functions and activities of the Indian Children's Program. Also presented are my recommendations about the future of the program.

First let me say that I am impressed with the dedicated staff that has been assembled to try and work with handicapped children. I am also impressed with what they are trying to do and hope that my comments and recommendations are not considered as criticisms of them but rather as my perceptions of the needs of multiple handicapped children throughout the entire IHS service area.

First: Comments about the present program.

1. It still is not clear to me what data has been used to determine the present functions and goals of the program. It appears that the program will accept any referral that comes in and then try to meet the need.

   Questions:

   A. How many "handicapped" children are there?
   B. What geographical area needs services?
   C. What services are needed and where?
   D. What existing services are available?

2. Politically and clinically the program is tied too tightly to the Albuquerque Area.
3. The program is becoming diversified into service research and contract program some of which are not necessarily related strongly with handicapping conditions.
4. There seemed to be a feeling from the staff that this program should remain autonomous from the rest of the IHS system. The lack of communication with IHS program staff appeared over and over again.

Second: Recommendations for the present program.

1. The present program should justify it's existence through presentation of hard data showing IHS needs in relation to handicapping conditions and data to prove that present program is meeting those needs efficiently and effectively.
2. Program must be integrated into the IHS comprehensive care system at the national, area and service unit level.
3. Management by objectives planning should be instituted immediately in conjunction with Maternal and Child health programs throughout IHS.
4. Program accountability should be strengthened thru the Division of Program Operations at Headquarters rather than through Division of Resource Coordination.

Thirdly: My recommendations for change in the program.

1. The program should become a national IHS program rather than a regional program.
   A. Integrate with the IHS child health programs to act as an advocate for multiple handicapped children by,

(i) Collecting and reviewing hard data for handicapping conditions so that management by objective planning can occur that will provide needed services to handicapped children.

(ii) Act as an instructor and motivator to child health staff in each area about the needs of handicapped children and how those needs can be met.

(iii) Review what services are presently available in each area and show areas how to more efficiently network these services.

(iv) Deliver clinical services to individual service units by evaluations, diagnosis, development of treatment plans, and monitoring of care of previously identified and screened service unit populations making sure that the primary responsibility of each child remains with the local health and education providers.

2. Integrate present Fetal Alcohol syndrome training and diagnosis with the activities as in A above.
3. Develop preventive programs for those handicapping conditions identified as most significant and most easily prevented.
4. Reevaluate present research projects and separate them from the Indian Childrens Program thus freeing up additional funds for direct services.
5. Evaluate present and future relationships with the BIA Office of Indian Education in regards to funding and program demands.
6. Support and supplement existing school health programs at the service unit level especially in regards to health needs of the handicapped.

In summary the two most important changes needed are (1) Integration of this program with the other child health programs of IHS by better communication and planning, and (2) Making this a National IHS program rather than a regional program.

Thank you for permitting me to make these comments.

ROBERT C. KREUZBURG, M.D.
Chief
Maternal and Child Health

cc: Ken Fleshman, MD
Senior Clinician Pediatrics
/s/ K.R. Fleishman

Prepared by: IHS/DPO/KREUZBURG/dnmnm/7-2-81

SIGNIFICANT ITEMS
HOUSE REPORT NO. 97-942
FY 1985 APPROPRIATIONS

ISSUE

Indian Children's Program—The House Appropriations Committee has stated that it ". . . . is pleased to hear of the continued success of the Indian Children's Program, and expects the Indian Health Service to include information in next years' budget justification regarding its participation and details of funds to be provided to this effort."

BACKGROUND

The Indian Children's Program (ICP) was begun by the Indian Health Service (IHS) under the authority of P.L. 94-437. In 1979 the Office of Indian Education Programs of the Bureau of Indian Affairs (BIA/OIEP) joined to support what has evolved into a true interagency activity.

The ICP has both a regional and national focus. Regionally, the ICP serves as an interagency project for emotionally, educationally, physically, and mentally handicapped American Indian children and youth in the southwest. For individual children, the ICP provided diagnosis, evaluation treatment planning and follow-up services. For parents, community groups, school personnel and health care personnel, the ICP provides training in child development, prevention of handicapping conditions, and care of the handicapped child. Nationally, the ICP is limited to providing training programs to the IHS and BIA service providers and community groups. It is, on occasion, involved in the care of individual handicapped children outside of the southwest. Because of the distance between the ICP in Albuquerque and handicapped American Indian children in other parts of the country (e.g., South Dakota), the ICP is attempting to develop a sys-

tem of care under which children could be seen by programs near their home. To that end, IHS and BIA/OIEP have entered into an agreement with the American Association of University Affiliated Programs for the Developmentally Disabled (AAUAP) to provide individual diagnostic evaluation and treatment planning services by member programs closer to the child's community.

Financially, the ICP is supported by both IHS and BIA/OIEP approximate 65:35 ratio. IHS base funds are expended under the Mental Health [illegible].

INTERAGENCY AGREEMENTS

	IHS Direct	IHS	BIA	NIMH	TOTAL
FY 1981	$599,205	$191,284	$129,000	$71,400	$990,889
		(from FY 81 $)			
FY 1982	450,200	110,000	297,306	72,600	936,106
		(from FY 82 $)			
FY 1983	520,500	116,127	334,096	0	970,723
		(from FY 83 $)			
FY 1984	520,500	130,000	[1]	0	[1]

[1] The BIA FY 1984 resources to be included in the interagency agreement have not been determined as yet.

ACTION

The Indian Health Service will continue the activities of the Indian Children's Program at the same level in 1984 as in 1983. IHS and BIA/OIEP will continue to share policy control.

The IHS and BIA will also continue discussions begun this year designed to develop a coordinated network of care for handicapped American Indian Children. It is hoped that out of these discussions will emerge a plan for a national partnership among federal, state, local, tribal governments and private organizations.

[SEAL]

DEPARTMENT OF HEALTH &
HUMAN SERVICES
Public Health Service
Indian Health Service

Indian Children Program
2401 12th St., N.W.
Albuquerque, New Mexico 87102
505/766-6675 766-2122

June 28, 1985

To: ICP Referral Sources

The ICP is currently re-evaluating its purpose and functions as a national mental health program for Indian children and adolescents. Historically we have been able to provide monthly consultation with people working with children identified as handicapped. This has been a rewarding activity both for us and for those we have served. The ICP, however, needs now to reassess how we may most effectively serve Indian children not only in the Southwest but among all Indian people across the nation. As you may sense, this is a difficult challenge, but we are hopeful that the ICP will emerge from this process as a program able to enhance the mental health of Indian children in an even more effective manner.

During this process of transition we will not be able to respond to clinical needs in the usual manner. We cannot accept new referrals except in emergency cases. We will see children whose referrals have been received prior to your receipt of this letter. We urge you to research other resources for your children, and we will be of any assistance possible in this search.

We as a staff are very concerned about continued care for the children we have served, and we will be actively involved in assuring continuity of care. We will keep you informed of the progress of our transition.

If you have any comments or questions, please feel free to contact us.

Sincerely,

/s/ Teresa Makowski
TERESA MAKOWSKI, PH.D.
Acting Clinical Director, ICP

/s/ Linda M. [illegible]
MARY ELLEN (MICKEY) PIERCE, M.S.
Acting Director of Administration, ICP

Appendix A

ICP STATISTICS

MARCH 83-JULY 1985

Month	New Contacts	F/U Contacts	Total Contacts	# Sites	# Sessions/ # People
March 83	45	70	115	32	6/313
April 83	45	55	100	29	7/570
May 83	39	67	106	27	15/421
June 83	45	80	125	21	2/35
July 83	60	71	131	21	1/8
August 83	51	65	116	22	6/162
September 83	26	90	116	32	5/180
October 83	25	96	121	27	5/101
November 83	58	49	107	21	5/95
December 83	29	93	122	29	7/79
January 84	35	129	164	32	4/69
February 84	56	91	147	29	6/166
March 84	35	122	157	30	8/96
April 84	49	93	142	36	10/91
May 84	41	100	141	34	9/128
June 84	35	106	141	18	6/161
July 84	32	120	152	24	3/20
August 84	40	108	148	25	7/197
September 84	42	138	180	38	9/305
October 84	22	123	145	35	9/270
November 84	34	103	137	33	12/145
December 84	22	40	62	18	10/485
January 85	42	139	181	35	8/117
February 85	34	130	164	24	6/85
March 85	18	72	90	24	8/187
April 85	44	85	129	27	9/132
May 85	42	101	143	28	6/122
June 85	6	58	64	12	1/122
July 85	8	45	53	13	2/67
TOTALS	1,060	2,639	3,699		192/4,983

#3722

UNITED STATES GOVERNMENT
MEMORANDUM

DATE: August 21, 1985

REPLY TO
ATTN OF: Acting Clinical Director, ICP
Acting Administrative Director, ICP

SUBJECT: Termination of Direct Clinical Services

TO: Service Unit Directors
Area Directors
Referral Sources

As you are probably aware, the Indian Children's Program has been involved in planning activities focusing on a national program effort. This process has included the termination of all direct clinical services to children in the Albuquerque, Navajo and Hopi reservation service areas. During the months of August and September, ICP staff will be seeing children followed by the program in an effort to update programs, identify alternative resources and facilitate obtaining alternative services. In communities where there are no identified resources, meetings with community service providers will be scheduled to facilitate the networking between agencies to secure or advocate for appropriate services.

Much effort and thought have been devoted to the accomplishment of an orderly and adequate termination of the direct service component of the program. We understand that this is a difficult transition for all involved, and we are motivated by our goal of increased mental health services for all Indian Children.

During our planning process we invite your input on how we may best assist you and your area in securing the types of services that have been provided by the Indian Children's Program. Direct clinical services are more appropriately provided on a local level and we can best serve children needing those services by providing you

with technical assistance in obtaining more local resources.

Please feel free to contact us if we can assist you with this change. Thank you for your support in the past and we wish for your continued support in our new effort.

/s/ Mary Ellen Pierce
MARY ELLEN PIERCE, M.S.

/s/ Teresa Y. Makowski
TERESA Y. MAKOWSKI, PH.D.

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF NEW MEXICO

No. CIV-86-1182 JB

GROVER VIGIL, ET AL., PLAINTIFFS

vs.

EVERETT R. RHOADES, ET AL., DEFENDANTS

THE DEPOSITION OF ALBERT HIAT

Taken by the Plaintiffs, pursuant to the Federal Rules of Civil Procedure, taken at 9:10 a.m. on the 27th day of May, 1987, * * *.

* * * * *

[21] Q. Without dragging us through every single year of the project's life, I would like to get some sense from you—and again we're not trying to put words in your mouth—of how much the staffing of the project changed over time. These memos help us establish what was going on in 1979. Would it be or would it not be correct to say that the staffing [22] remained pretty much at that level until 1985?

A. In terms of the mix of people, it was basically the same. There may have been some additions and some changes, but you know basically we had a mixture of therapists, of different types of mental health people and medical people.

Q. But the number of authorized positions didn't change radically at any time in that six years?

A. Well, I don't remember. But again, it fluctuated. You know, we had different numbers of people at different times, and a lot of that had to do with being able to hire people. At various times, people in these categories were difficult to hire. They were very much in demand, at least, and it was difficult to attract people who were willing to travel, so there were some fluctuations in staffing.

Q. Would the fluctuations—I took down a list very quickly, and let me just read it back to you. I believe this is from your testimony before. And certainly if it is inaccurate, you can change it. But you characterized the staffing as having a pediatrician, a child psychologist, two additional clinical psychologists, a developmental psychologist, two physical therapists, two occupational therapists, a social worker, a social worker associate, a vocational rehab person and two education diagnosticians. That would be 14, and yourself would be about 15 positions. Is that—

[23] A. Yes, but that varied. It went up and down, I'd say, by three or four people sometimes.

Q. So at the height of it, you might have had 19 to 11? Would that be a correct range?

A. Yes, or say 11 to 15 or 16. I don't think it ever went as high as 19 approved positions. And I'd like to make another correction. There was a child psychiatrist.

* * * * *

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF NEW MEXICO

(Caption Omitted in Printing)

THE DEPOSITION OF
MARY ELLEN SANCHEZ

Taken by the Plaintiffs, pursuant to the Federal Rules of Civil Procedure, taken at 9:30 a.m. on the 29th day of May, 1987, * * *.

* * * * *

[43] Q. I'd like to ask you some questions relating to —let me ask you first: Were you involved in closing out the clinical cases?

[44] A. Yes.

Q. What was your involvement in that?

A. We had meetings where we took communities and —let me back up. We met as the clinical staff and, by community, identified those children in the community that we were seeing on an ongoing basis. From that, lists were compiled, by community, of the children that were being seen, and we met to decide who would write a case summary on each child. And in most cases, it was the primary service provider who would be following that child. But because of the BIA staff not being able to be actively involved, there were a number of children who, their active caseperson was a BIA staff who could not be involved, so we split that work up among those of us that were left.

Q. Who all was involved in the process you've just described?

A. Catherine Baca, who was the pediatrician; Katherine Burke-Griffin, who was the speech pathologist;

Mary Thompson-Hudson, the physical therapist; Teresa Makowski, the clinical psychologist; myself. That was it.

Q. And do you remember how many cases you had to close out, how many cases there were at the time you started this closing out process?

A. There were around 400.

Q. So that would mean that each person was doing [45] approximately—let me divide quickly—75 to 100 cases?

A. No, we didn't divide them like that. What we did was, the ones that were more motor related Mary Thompson-Hudson did because she's a physical therapist and she could read the charts and interpret that information. The ones that were more speech related, Kathy Burke-Griffin did those. They did significant numbers of the work. The pediatrician, Catherine Baca, did a significant number because she was a pediatrician and understood diagnoses. Terry Makowski did the mental health cases. She was a psychologist and could interpret those. And I kind of did those that were left over.

Q. That nobody else wanted?

A. Right.

Q. What goes into a case summary?

A. There was a lot of discussion about what to include. We included some background information, as I remember, and we had what our role was with that child. For instance, if a child was involved in Head Start and we were providing evaluations and monthly follow-up, that's what it would say. We talked about the background a little bit and we talked about our involvement or our current role with that child, and then the plan as what we thought should happen so that services would continue with that child. I don't remember if there were other sections involved in it or not, because there was a format that we followed so that they would all be in the same format.

[46] Q. Once those case summaries were written, what happened to them?

A. We had a community meeting in each community. And before we had the meeting, we identified community coordinators or contact people, who were asked from our end if they would coordinate the meeting plus also be responsible for receiving the case summaries and for assuming the role of case manager for these children.

Q. What do you mean by "case manager"?

A. Case manager would be that she would—if there were resources available in the community, she would match those resources with the children. If there were not resources in the community, that some sort of periodic review of the child's chart or an appointment would be made to review that chart with a pediatrician or whoever was available in the IHS facility.

* * * * *

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF NEW MEXICO

(Caption Omitted in Printing)

THE DEPOSITION OF
WILLIAM B. HUNTER, III

Taken by the Plaintiffs, pursuant to the Federal Rules of Civil Procedure, taken at 10:00 a.m. on the 17th day of July, 1987, * * *.

* * * * *

[99] Q. When you first became Acting Chief in January of 1985, was that the first time that you really had responsibility for the Indian Children's Program of any nature?

A. Yes.

Q. And you were taking over from Dr. Townsley?

A. No.

Q. Excuse me, which—

A. Dr. Ellis.

Q. Did Dr. Ellis give you any particular instructions about the Indian Children's Program?

A. No. There was no reason why he should.

Q. Nothing in particular was going on in regard to issues with that program at that time?

A. Oh, yes, they had been going on from the time I came into the Indian Health Service, the inappropriateness of some of the services that we were providing that were direct services.

Q. Tell me a little bit more about that. When did you [100] first hear that—I can't reproduce the phrase, but

the phrase you just used, the inappropriateness of the services, when did you first hear that and from whom?

A. The first time that I heard it discussed was in the fall of 1983, when several of us went back to Rockville, and the fact that the Indian Children's Program was a national program providing direct services to a small, relatively small, regional area was discussed. I don't remember the nature of those conversations. I had only been in the Indian Health Service for a month or so, and I was meeting new people. That was the first time I went back to Rockville. It came up off and on again over and over.

Q. Can you recall who was making those remarks in Rockville? I don't mean necessarily any one person, but a group of people or several people. Can you put any names with that?

A. Dr. Krusberg was talking about it. It was a subject of discussion and disagreement in our office—

Q. The Mental Health—

A. Well, I mean within the Indian Children's Program. And the people in the Mental Health Programs Branch wouldn't get together and just talk about the Indian Children's Program, and it came up in rather interesting sorts of ways in the areas.

Q. Can you expand on that? What were the different sorts [101] of ways?

A. Well, I would hear that the areas didn't know what the Indian Children's Program did. I remember specifically being down at Mescalero and mentioning the Indian Children's Program because I was trying to promote the Indian Children's Program to Mr. Hardwick, who was then the Area Director of the Albuquerque Area. And he said, "I sure would like to know what they do in Albuquerque, in the Albuquerque Area."

Q. Within the Indian Health Service?

A. Yes. That's not to say they weren't doing anything.

Q. You mentioned that Dr. Krusberg, back at the national office, had this concern. Can you recall what his title was at that time?

A. No, I can't.

Q. Would that have been when he was Dr. Vanderwagen's superior?

A. At that point in time I don't think Dr. Vanderwagen was even in Rockville. I think that there was a Dr. Swetter who was there. There was a Dr. Paulson, who then was in the position that Dr. Vanderwagen came to occupy relative to us. Dr. Swetter was over us and Paulson was over us. I didn't know these people. There was such a turnover, I never really got to know them, except for Dr. Vanderwagen.

But you know, the concerns about the thrust of the program with a major part of its resources going to local [102] endeavors were expressed from the time I came in. And I think the expressions that I heard, the concerns, came from the fact that the services provided were not what was originally the intent of the Indian Children's Program, which was to have been the Indian Children's Village. And as a result, what was to have been a resource for all Indian people, all Indian handicapped children, nationally, had become focused on essentially a chunk of the Albuquerque Area, the majority of the Albuquerque Area and part of the Navajo Area and a very selective part of the Phoenix Area.

And the Headquarters concern back in Rockville resulted from the justifiable resentment on the part of all the other areas that services that they had been promised weren't forthcoming and these services were being focused in a very narrow segment of the population, who were being provided, even with the services provided by the Indian Children's Program, being provided very inadequate services, and the other areas were getting nothing.

Initially it was to have been a residential treatment center which was a resource to the entire Indian population, the population of handicapped Indian children.

Q. So that was the concern, that it was providing a service to a local area, and was a national—

A. It was a national program.

Q. And that was expressed by Dr. Krusberg? Was it [103] expressed to you by other people when you first started in 1983 or later on?

A. I'm sure it was because—I don't know who, but it seemed to me that it was a general topic of conversation. It wasn't a major topic of conservation. I mean we talked about a lot of other things, you know, when we'd go back to Rockville. But if someone would offhand say, "How are you all going to keep justifying that program?" I mean it seemed to me that it was a theme that had become emergent before I came in and continued to do so.

Q. Isn't it generally true that there is a variance in services throughout the Indian Health Service from area to area?

A. I think that there are.

Q. But this was seen as a big problem specifically with the Indian Children's Program?

A. There's no question about the disparity in services. The question had to do with the appropriateness of focusing ongoing—some form of ongoing clinical services out of a national office into a small area. So that the question was, as I understood it, should—the Indian Children's Program was to be a national resource, not a local resource, and the concern was how to make it a national resource.

* * * * *

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF NEW MEXICO

(Caption Omitted in Printing)

DEPOSITION OF W. CRAIG VANDERWAGEN, M.D.

* * * * *

[33] Q. What kind of services did the ICP provide your clients?

A. Staff.

Q. Your staff?

A. And the patients.

Q. And the clients' staff.

A. They would come out periodically, and it was in [34] the range of six to eight weeks, and with prior agreement with our local people, various children would be brought in for diagnostic evaluation, primarily. That was the primary function from our point of view.

They would provide consultation to the pediatrician, in particular, as to was his diagnosis essentially correct and might expand his diagnosis a bit, in terms of the particular needs for disciplined, specific kinds of activity.

An example, a child with cerebral palsy, longstanding, well-known, not a new case, they might come and assess progress, or lack thereof, or regression in the tonus of the muscles and the flexibility of the limbs and that sort of thing and provide some diagnostic, prognostic information for the pediatricians or the community health nurse, who would do outreach with the patients, and the parents were usually present as well.

The responsibility for following through on any treatment modalities for these children, basically, was ours.

That is, through the use of local resources, staff, contract health service dollars, Crippled Children's, United Way, whatever resources we could bring to bear on [35] the issue to do follow-up services, based on some of their prognostic and diagnostic input, which was confirmatory and expansive to the pediatrician's existing diagnosis.

Q. When you say, "Crippled Children's," what were you referencing, is that some sort of agency?

A. Yes, it's a state funded—well, actually, I think it's a private, nonprofit entity in the State of New Mexico, which provides funding for various services for children. That runs the gamut from paying for level-three nursery care for newborns, high-risk pregnancy up to services for kids with cerebral palsy or other physically disabling conditions.

Q. Is that separate from the Carrie Tingley, from the chillren's hospital or—

A. Yes.

Q. That was a separate entity?

A. Sure. Again, another resource that was available to us, but, again, we used them when they could help us with what we needed done.

* * * * *

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF NEW MEXICO

(Caption Omitted in Printing)

DEPOSITION OF ANN GALLOWAY-LEIGH

BE IT REMEMBERED that on to-wit, the thirtieth day of September, 1987, this matter came on for the taking of the deposition of ANN GALLOWAY-LEIGH * * *.

* * * * *

[63] Q Did the BIA-ICP continue to receive all the funding that it had originally been receiving?

A Yes.

Q To this date?

A Yes.

Q And that funding involved the providing of direct services?

[64] A Yes, that's what it was for.

Q Just in the southwest area?

A Yes.

Q So does the BIA-ICP still exist?

A There is no BIA-ICP by name, the services provided under contract are continuing to date because of the confusion. Because the ICP was not doing services, it was decided to change the name so that it would be a bureau function with a new name, same services provided.

Q And when did that decision take place?

A December, January of '85.

Q And what was the name changed to?

A ISET, Indian Student Evaluation Team.

Q Was there any difference in the function of ISET?

A ISET provided services to bureau enrolled handicapped or suspected handicapped children, the same as ICP had.

Q What would be the differences?

A The difference is that the bureau funding did not allow us to see children who were not legally enrolled in bureau schools. Having IHS funding allowed us to see—or allowed the program to see other students. The bureau funding has always been mandated to those legally enrolled in bureau schools, so we didn't—I mean "we" became a separate team.

* * * * *

[104] Q I have a question that dates back to a question we discussed earlier. Were actual therapy services ever provided by ICP staff to individual children?

A Define "therapy service," from your term for me.

Q Laying on the hands, physical therapy.

A Let me define for you, if I can, what we call it. There are two types of therapy service; one would be direct or primary therapy which would be a professional who would provide services at least on a weekly basis. The Indian program did not do that. We never provided, and could not provide, weekly services. We could not be the direct or primary therapist.

[105] There's another level of therapy called consultative or secondary. That would be either you consult with the primary therapist for ideas, or you work with paraprofessionals, train them to do daily or weekly therapy, and you would be their professional back-up who might see them monthly or over a couple of months. That type of therapy we did work with.

* * * * *

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF NEW MEXICO

(Caption Omitted in Printing)

PLAINTIFFS' INTERROGATORIES TO DEFENDANT ROSS SWIMMER

1. Describe in detail the creation and operation of the ICP, including but not limited to the date on which the ICP was created, the mission of the ICP, and the services, if any, provided to individual handicapped children by the ICP.

ANSWER: ICP was created by IHS and operated by IHS prior to BIA involvement. The Bureau became involved by a directive through Congressman Yates in 1979. A Memorandum Of Understanding was signed for a one year period for the first year of joint operation in 1979 and was not signed thereafter. The joint mission was to see if the two agencies could have any sort of collaborative program. The services were twofold. IHS's initial purpose was to look at the establishment of a brick and mortar building that would be an in-patient treatment facility for handicapped Indian children and to provide an interagency multidisciplinary team that would provide on site services to suspected and or handicapped Indian children. The Bureau's purpose, on the other hand, was based on a "state plan" that was submitted to Bureau for Education of the Handicapped in 1976, 1977, 1978. The Bureau agreed with IHS to join in the expansion of the ICP to include educational types of staff. For the First year the program was limited to the southwest region for direct services and assisted BIA schools in the

southwest region in meeting compliance standards for P.L. 94-142. BIA services under the ICP were intended to be secondary to the primary P.L. 94-142 services of BIA schools. Co-equal emphasis was to be given to the health as well as the educational needs of the referred Indian children. Medical, educational, diagnostics and treatment planning services were to be provided through the ICP project through existing local service providers under contract or through direct services provided or arranged by IHS or BIA as appropriate, consistent with the concept of providing services to handicapped Indian children in the least restrictive environment.

2. State the date the BIA became involved with the ICP and describe in detail the extent of that involvement.

ANSWER: The BIA became involved with ICP in July 1979 when Ann Leigh was designated as Codirector of the ICP project. BIA's involvement was to supplement the IHS's existing ICP with educational staff by providing diagnostic and treatment planning services for handicapped Indian children and parent and/or staff training in the implementation of these treatment plans.

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF NEW MEXICO

(Caption Omitted in Printing)

DEFENDANTS' RESPONSE TO PLAINTIFFS' SECOND REQUEST FOR ADMISSIONS

The Federal Defendants submit the following answers to plaintiff's second request for admissions:

* * * * *

129. The IHS decision to reduce or terminate ICP services provided directly to handicapped children was not based on the availability of alternative community resources or other local resources.

RESPONSE: Deny.

130. Prior to October of 1985 there was no direct reduction in the operating budget of the ICP.

RESPONSE: Admit.

131. The IHS decision to reduce or terminate ICP services provided directly to handicapped children in the southwestern region was not the direct result of a cut in the ICP budget.

RESPONSE: Admit.

132. The ICP employed an interdisciplinary team within which were represented the following disciplines: clinical psychology, developmental pediatrics, developmental psychology, child psychiatry, educational diagnostics, speech/language therapy, occupational therapy, physical therapy, vocational rehabilitation, therapy, recreational/art therapy, social work.

RESPONSE: Admit.

133. A major priority of the ICP was the long-term treatment planning and follow-up of individual clients.

RESPONSE: Deny except to admit that long term treatment planning and follow-up of individual clients became an ICP staff priority as the program developed after 1980.

134. Many of the children seen by the ICP suffered chronic problems which require long-term involvement.

RESPONSE: Admit.

135. Early detection and intervention services for handicapped children are crucial.

RESPONSE: Admit.

136. Without early detection and intervention services for handicapped children, many pre-school children will be further handicapped by the time they reach school programs for the handicapped.

RESPONSE: Admit.

137. The BIA did not provide written notice to the parents or guardians of the children for whom ICP services were terminated or whose ICP cases were closed out on or after October 1, 1985.

RESPONSE: Admit that the BIA did not provide written notice to the parents or guardians of the handicapped Indian children who were not enrolled in BIA schools for which ICP services were terminated or whose ICP cases were closed out on or after October 1, 1985.

138. The IHS did not provide written notice to the parents or guardians of the children for whom ICP services were terminated or whose ICP cases were closed out on or after October 1, 1985.

RESPONSE: Admit.

139. The ICP staff made a conscious decision not to provide written notice to the parents or guardians of children for whom ICP services were terminated or whose ICP cases were closed out on or after October 1, 1985.

RESPONSE: Deny except to admit that ICP staff notified referral sources who had the responsibility to notify parents.

140. The ICP no longer exists.

RESPONSE: Deny except to admit that the ICP as it existed in 1985 no longer exists.

141. The IHS failed to ensure that the decision to terminate ICP services provided directly to children in the southwestern region was available for public inspection and copying.

RESPONSE: Deny.

142. The IHS failed to publish any notice in the Federal Register in connection with the proposed or final decision to redirect the ICP or to reduce or terminate the ICP services provided directly to children in the southwestern region.

RESPONSE: Admit.

143. The IHS failed to advertise or otherwise attempt to hire persons to fill any of the positions vacated by ICP staff in 1985 or 1986.

RESPONSE: Deny.

144. ICP services were available to children from birth through twenty-one years of age who had or were suspected of having, or were at risk of having a physical, mental, emotional handicap or combination of handicaps and who were eligible for services from the IHS or the BIA.

RESPONSE: Deny except to admit that this describes the population eligible for ICP services during the time the ICP was a joint IHS/BIA pilot project. Thereafter, BIA continued to serve only those handicapped Indian children who were enrolled in BIA schools.

145. ICP services were available to eligible clients regardless of severity of handicap.

RESPONSE: Admit.

Dated: October 9, 1987

/s/ Duke McCloud
DUKE MCCLOUD
Senior Attorney
Public Health Division
Attorney for Federal Defendants

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